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PREGNANT AND PARENTING TEENAGERS IN MASSACHUSETTS

MASSACHUSETTS CAUCUS OF WOMEN LEGISLATORS
TASK FORCE ON PREGNANT AND PARENTING TEENS

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ADOLESCENT HEALTH CARE
PART I

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THE TASK FORCE ON PREGNANT AND PARENTING TEENAGERS
IN MASSACHUSETTS

EXTENDS SINCERE THANKS TO

THE MASSACHUSETTS CAUCUS OF WOMEN LEGISLATORS

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KAREN SULLIVAN

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OVERVIEW: ADOLESCENTS AND THEIR HEALTH

While teenage pregnancy, early parenthood, and their consequences are the main focus and concern of this report, they must be viewed in the context of the many personal, social, environmental, physical and mental health problems that are confronting adolescents, and being experienced by them in society today. They must be placed in the constellation of adolescent needs and issues - all of which give cause for grave concern, and lend a sense of urgency and immediacy to our efforts to confront these issues at their core by mobilizing all resources to address and resolve them.

There are over 20 million 15 to 19 year old adolescents in the United States. There are another 18 million 10 to 14 year old pre-adolescents and adolescents following along behind them.[1]

Recent studies indicate an increasing concern about the overall poor health of adolescents in the United States today.[2] Some research implicates the lifestyle factors of diet, exercise, and stress in the poor health of teenagers.[3] Once thought to be an "invincible" group in society, adolescents are now considered as being physically unfit and generally unhealthy. "Since the early 1960's, the general health of adolescents has declined", stated Dr. Joseph Zanga, chairman of the American Academy of Pediatrics' Committee on School Health, in a recent study on the health status of adolescents.

In research from the Kansas City, Missouri Health Department, where school health programs have been established for several years, and are currently in the process of being evaluated, it was found that "two-thirds of the students who had

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registered in the school program indicated that they probably would not have sought medical services for their presenting problems at another facility." A survey of the student population indicated that over one-half of the students had no regular physician, and 17% could not remember the last time they had seen a physician.[4] Other studies have confirmed that 4 to 6 out of every 10 adolescents in the United States are not receiving regular medical services.[5]

In addition to an overall lack of, or inadequacy of, general health care and health promotion among a large number of adolescents and pre-adolescents, "at very early ages, advantaged children are told more about maintaining health than disadvantaged children."[6] This applies also to adolescents, and involves the consistency and quality of the level of availability, accessibility, and affordability of health care and health promotion in their lives.

According to many studies nationwide, the mental health of adolescents is far from good. Again, from the American Academy of Pediatrics' Committee on School Health, "countless adolescents today are going through severe emotional turmoil without the help, support, and guidance they need."[7]

While adolescence should be a relatively healthy time of life, "the health effects of the problem behaviors are significant, documented by the high rates of alcohol and drug abuse, suicide and psychiatric admissions among this age group. Certain adolescents have little access to private medical care."[8]

Teenagers are reporting more psychosomatic symptoms than ever before, and are experiencing higher rates of stress-related syndromes than in the previous two decades.

SUICIDE

One in ten adolescents in the United States suffer from severe depression. One in five psychiatric patients in the United States is under 18 years of age.[9]

While suicide rates have risen considerably internationally among young people, the U.S. has the highest rate of suicide among this age group. The suicide rate among 15-24 year olds has more than tripled in the past 20 years. According to the National Center for Health Statistics, in a study done in the spring of 1984, the suicide rate for 10-24 year olds has increased 33% since 1970.[10] A recent report in January, 1985, stated that suicide is the third leading cause of death among adolescents ages 15-19 years, and the fifth leading cause of death among children ages 10-15 years.[11] According to the American Academy of Pediatrics, 6,000 teenagers killed themselves in 1984. This means one suicide every 90 minutes. More than 500,000 young people attempt to take their own lives each year. While 90% of those attempting suicides are females, most of those who actually do commit suicide are boys. There are recent studies that indicate that possibly two-thirds of teen suicides are committed with guns belonging to persons living in the teenagers' homes.

In their 1986 Statistical Bulletin, a report from the Metropolitan Life Insurance Co. stated that the number of children under age 15 who have committed suicide increased from just under 40 a year in 1950, to about 300 a year in the 1980's.

In Massachusetts, between 1980 and 1984, there were 176 teen suicides. The rate of suicide among adolescents in 1984 was 9.4 per 100,000, or 1 in 10,000, ranking Massachusetts the third lowest in the United States. In the past two years, Massachusetts has experienced an increase in the number of suicides completed, and in the number of suicide attempts among adolescents. In 1985 and 1986, there have been 15 known suicides among adolescents, and 50-75 known attempted suicides.[12]

SUBSTANCE USE AND ABUSE

Adolescents face constant pressures to drink, to smoke, and to become involved in drugs. Richard Jessor, Director of the Institute of Behavioral Science at the University of Colorado, concluded in a report that "teenage drug abuse is associated with a syndrome of unhealthy behaviors."[13]

The statistics measuring the effects of the stress and problems being experienced by adolescents are alarming. The National Institute on Alcohol Abuse and Alcoholism estimates that 1.3 million teenagers have serious drinking problems, and that substance abuse is now the leading cause of death among teenagers. Teenage drivers are responsible for 17 million alcohol-related accidents a year.

In a survey conducted among 1985 high school seniors by the University of Michigan and the National Institute on Drug Abuse, results indicated that "after a five year decline in adolescent use of alcohol, tobacco, and illegal drugs, the 1985 results indicated a stabilization of use and abuse of some substances, and an increase in the use of cocaine. Cocaine use was reported to be at the highest rate of use ever detected in the 10 previous surveys." The survey report stated that 17.3% of the students had tried cocaine at some time, and cocaine use had doubled among school children.

About 61% of the surveyed students in 1985 had tried some type of illegal drug; 30% had tried marijuana in the month prior to the survey, while 54% had tried it at some time. The use of amphetimines is the second most widely used substance after marijuana. Over 93% of the students had tried alcohol at some time in their lives; 45% of the boys and 28% of the girls reported drinking heavily.

In a Massachusetts survey conducted in 1984 with seniors* and with students in grades 9-12,[14] results indicated that 89.9% of the students in grades 9-12 and 94.9% of the seniors stated that they had tried alcohol at some time in their lives.** In the same survey, 58.6% of all students and 71.1% of the seniors

* It should be noted that the Mass. survey was conducted in the fall, or at the beginning of the senior year; the national survey is done annually at the end of the senior year in the spring. Therefore, seniors are several months younger in the Mass. survey than they are in the national survey.

** Lifetime use means that the substance has been tried at least once, or was being used occasionally, frequently, or that a student tried once and quit.

reported being current users of alcohol. In a survey of 7th and 8th graders, 63% reported trying alcohol at some time, and 25% reported being current users of alcohol.

In the same survey, 60% of students in grades 9-12, and 70% of the seniors reported use of illegal drugs at some time in their lives; 31% of all students reported being current users. In the use of marijuana, 51.2% of all students and 63.9% of the seniors reported using it at some time, and 27.7% of all students and 35.9% of the seniors stated that they were current users. Over 24% stated they had used amphetimines; 29.9% of the seniors used them. Over 6% of all students and over 8% of the seniors were current users of amphetimines. In the use of cocaine, 17.4% of all students, and 25.6% of the seniors stated that they had used it; 7.4% of all students and 12.6% of the seniors were current users of cocaine.

PHYSICAL AND SEXUAL ABUSE

According to the American Humane Association, "adolescents between the ages of 11 and 17 years represent 37% of all documented cases of child abuse. Among adolescents, there is a rise in emotional abuse, sexual abuse, and psychological patterns of maltreatment, including neglect. What these statistics do not reveal is that adolescent abuse is often masked by other behavior such as running away, suicide, school failure, drug abuse, teen pregnancy, and juvenile delinquency-making recognition difficult."[15] Studies have found that 70% of school dropouts suffer from some form of family abuse. Other research indicates that 75% of runaways are running from some form of abuse, neglect, and frequently, sexual abuse. In a 1984 study from Northeastern University, it was stated that 42% of all abuse and neglect cases involve adolescents.

In 1984, the Department of Mental Health reported that Massachusetts has

1.9 million children, adolescents, and youth under the age of 22 years. Estimates of the prevalence of mental illness in this age group ranges from 8% to 15%. Using the conservative figure of 8%, Massachusetts has approximately 152,000 children and youth who may be experiencing emotional problems and who are in need of mental health services. Within the total youth population, approximately 2.5% or 48,000 children and adolescents may be severely emotionally disturbed.

SEXUALLY TRANSMITTED DISEASES

Recent nationwide reports reflect concern over "an epidemic of sexually transmitted diseases that now threatens the health and well-being of millions of adolescents."[16] And, from another report, "sexually transmitted diseases present a greater health risk than ever, as new diseases with high morbidity and mortality threaten young people."

In Massachusetts, in 1980, there were 10,795 cases of gonorrhea for all age groups. Children ages 0-14 years accounted for 68 cases, and adolescents ages 15-19 years accounted for 1,988 cases. In 1984, children ages 0-14 accounted for an increase to 102 cases, or 1% of all cases, and adolescents accounted for 1,844, or 19% of all cases, which totaled 9,799. In 1980, there were 318 cases of syphillis in all age groups. There were no cases for children ages 0-14 years. Adolescents ages 15-19 years accounted for 13 cases. In 1984, while the total number of cases declined to 294, adolescents ages 15-19 years accounted for 30 cases, or 10% of the total number of cases for that year. The total number of herpes cases in 1980 for all ages was 873; the total number in 1983 was 1,118. There are no age breakdowns available for herpes cases. (See Table 1: Source: Mass. Dept. of Public Health)

DEATH RATES

In 1979 the U.S. Surgeon General reported that death rates were down

significantly since 1960 for all age categories, except for 15-24 year olds. Their death rate was higher than it had been 20 years ago. This report listed four behavioral factors most responsible for three-quarters of all deaths in this age group: traffic accidents, primarily caused by driving under the influence of alcohol and drugs; other accidents; suicide; and homicide. This report also concluded that the present life style patterns of adolescents could very well negatively effect their susceptibility to diseases later in life.

Results from a study published in the New England Journal of Medicine in 1985, entitled, "Racial and Socioeconomic Disparities in Childhood Mortality in Boston" stated that over the eight year period of the study, "57% of all deaths in adolescents were due to only two causes: injuries to occupants of motor vehicles and homicide. Overall, homicide claimed more lives during the period under study than any other form of injury-related death. Although mortality from homicide was highest among adolescents, it is important to note that 28.5% of all deaths from homicide occurred in children younger than 14, and 15.5% in children under 4."

Most widespread of the destructive activities young people take part in are drug abuse, alcoholism, and reckless driving. Suicidal acts and drug abuse are symptoms of deep psychological pain, despondency, depression, feelings of worthlessness and helplessness.

ADOLESCENT DEVELOPMENTAL STAGES

The teenage years are the time when various needs, issues, and growth patterns are emerging and confronting adolescents. How these are dealt with, met and resolved are of significance to individual maturity, fulfillment, and ability to participate in, and function competently and comfortably within one's own life experiences and society at large. These stages, or issues are:[17]

the establishment of an individual separate identity
the capacity to become involved in healthy, intimate love relationships
the capacity to function independently
the ability to trust and to think well of oneself
an appetite for growth and new experience and to perform work that is both gratifying and meaningful

Clearly, any and all of the problems stated, along with too-early pregnancy and parenting and the serious long-term consequences that frequently accompany childbearing among young teens, interfere with, and are disruptive of, these stages and their successful resolution. This, then, interrupts the life experiences and life options for these young people, in the present, and in their future.

PREGNANCY, CHILDBIRTH, AND PARENTHOOD

In the latter half of this century, teenage pregnancy has become one of the major public health and social problems of our time. The number of premature infants and infants born with illnesses and developmental disabilities, the infant mortality rate, the health complications to mother and child, and the number of deaths among the teenagers themselves, as compared to older women who give birth, have all greatly increased. Along with these health matters, "there is an extraordinary effect of these pregnancies upon our society: teenagers and their children must be housed, fed, clothed, educated, and cared for, which calls for an enormous commitment of government and private resources."[18] The teenager who attempts to complete her education, care for the child, and try to work towards becoming self-sufficient, is all too often crushed by the realities of early pregnancy and childbearing.

The fact that teenage pregnancy and childbearing has been recently brought to the forefront of national attention, and gained widespread media coverage and concern, does not mean that the problem itself is a recent or a new one. There

have always been large numbers of teenage parents, but public awareness has now begun to catch up with the problem itself in terms of confrontation of the issue and in terms of solutions afforded to adolescents to help them resolve the issue.

The problem of teenage pregnancy is particularly serious in the United States, which has the highest rates of teenage pregnancy and birth in the western world.[19] The pregnancy rate among teenagers is more than two times higher than that of Canada, England, and France; almost three times higher than that of Sweden, and seven times higher than that of the Netherlands.

In 1972, 95.1 of every 1,000 young women in the U.S. between 15 and 19 years old became pregnant. By 1981, the rate had risen to 110.8 per 1,000. During these same years, birth rates dropped, from 61.7 per 1,000 in 1972, to 52.7 in 1981. In 1970, the birthrate among girls between 10 and 14 years old was 1.2/1000; in 1982, the rate was 1.1/1000.[20] Four in ten of today's 20 year old women have had at least one pregnancy while in their teens. Two in ten have had at least one birth, and more than one in seven has had at least one abortion.[21]

According to reports from studies done by the Alan Guttmacher Institute in Washington, D.C., "if the trend continues, 40% of all teenagers who are now 14 years old will be pregnant at least once before they reach the age of 20 years". From yet another study,[22] "every day more than 3,000 teenagers become pregnant. At this rate, 39 out of every 100 girls who are fourteen years old today will become pregnant at least once before they reach the age of twenty. Twenty-one of these teenagers will give birth at least once, 15 will have at least one abortion, and 6 will have at least one miscarriage or stillbirth."

While pregnancy rates among teenagers are increasing, birthrates are slowly declining. Reasons that may account for the apparent descrepancy between

rising teenage pregnancy rates and single motherhood, and falling teenage birthrates are that "more teenage mothers are deciding not to get married, but to keep their babies. The availability of legal abortion offers an option for pregnant teenagers that has only been available in the past decade."[23]

Each year, over one million teenage women become pregnant. In 1980, 48% of these gave birth, 39% obtained an abortion, and 13% miscarried. In that same year, 562,300 teenagers gave birth, accounting for 16% of all births and 28% of all first births. Almost 272,000 teenagers had their babies while unmarried. In 1980, teens 17 years of age and younger gave birth to 208,000 babies. Almost 200,000 had abortions in this age group.[24] Over 30% of all abortions in the United States are to teenagers.

In 1980, among teenage women ages 15-19, 4.5% of all white teens and 9.5% of all other race/ethnic teenagers had a birth. Birthrates among black teenagers have fallen more sharply than among white teenagers; however, the birthrate for black teenagers is still higher than for whites.[25] In 1980, 3.8% of all whites and 6.6% of all teens who were of other race/ethnic origins, had an abortion.

In 1960, 6800 babies were born to teenagers under 15 years old. By 1982, this number of births had reached 10,000.[26]

According to a recent study conducted by the Center for Population Options in Washington, 1 out of every 3 female American women becomes pregnant before age 20 years. When this is broken down by age:

3% become pregnant by age 14 years
7% by age 15 years
14% by age 16 years
22% by age 17 years
31% by age 18 years
39% by age 19 years

According to the National Center for Health Statistics, there are 1.1 million teenage mothers in the United States. Last year, teenage mothers gave

birth to over one-half million babies. Teenagers are having babies at younger ages, and they are having babies at a rate of 1,540 a day, about 64 an hour.[27] Of these, about 93% decide to keep and raise their children themselves. In 1965, 35% of teenagers who gave birth placed their babies for adoption. In 1985, only 5% decided to place their babies. About 30% of these mothers become pregnant again within two years; 20% become pregnant again within one year. The birthrate for teenagers ages 15-17 years old, in 1981, was 32.5/1000. About 10% of all teenage girls, ages 15-19 years old, gave birth in 1985.

Teen mothers have nearly twice as many children as do older women. Despite the declining birthrate, there are 1.4 million children now living with teenage mothers, 50-60% of whom are unmarried.[28] An additional 1.6 million children under age five are living with mothers who were teenagers when they gave birth.[29] About 82% of teenage women who gave birth at age 16 years and younger were daughters of teenage mothers.

In 1984, in Massachusetts, there were 478,534 teenagers, ages 15-19 years. In that same year, there were 395,788 teens and pre-teens, ages 10-14 years.

After a period of declining births among teens in Massachusetts, (see table two), there are recent indications of an increase. In 1982, there were 7,361 births to teenage women, ages 13-19 years old. In 1983, this number declined to 6,919. In 1984, there was an increase of 97 births over 1983, with a total of teen births of 7,016. In 1984, teenagers gave birth to 9.0% of the total births in Massachusetts for that year.

The following table gives teenage births in Massachusetts, by age of the mother, the percent of teen births to total births, and total births of all ages, for the past five years.

		Age of Mother									
Year	Total Births	12	13	14	15	16	17	18	19	Total 12-19	Percent of Total Births
1980	72,591	1	14	56	300	740	1360	2202	3092	7765	10.7
1981	73,931	1	12	82	275	722	1357	2164	2816	7429	10.0
1982	75,749	1	14	83	299	753	1328	2161	2722	7361	9.7
1983	76,031	0	8	78	255	726	1278	2053	2521	6919	9.1
1984	78,198	9 (combined)		75	265	714	1307	2061	2585	7016	9.0

Data Source: Mass. Dept. of Public Health: Division of Health Statistics and Research

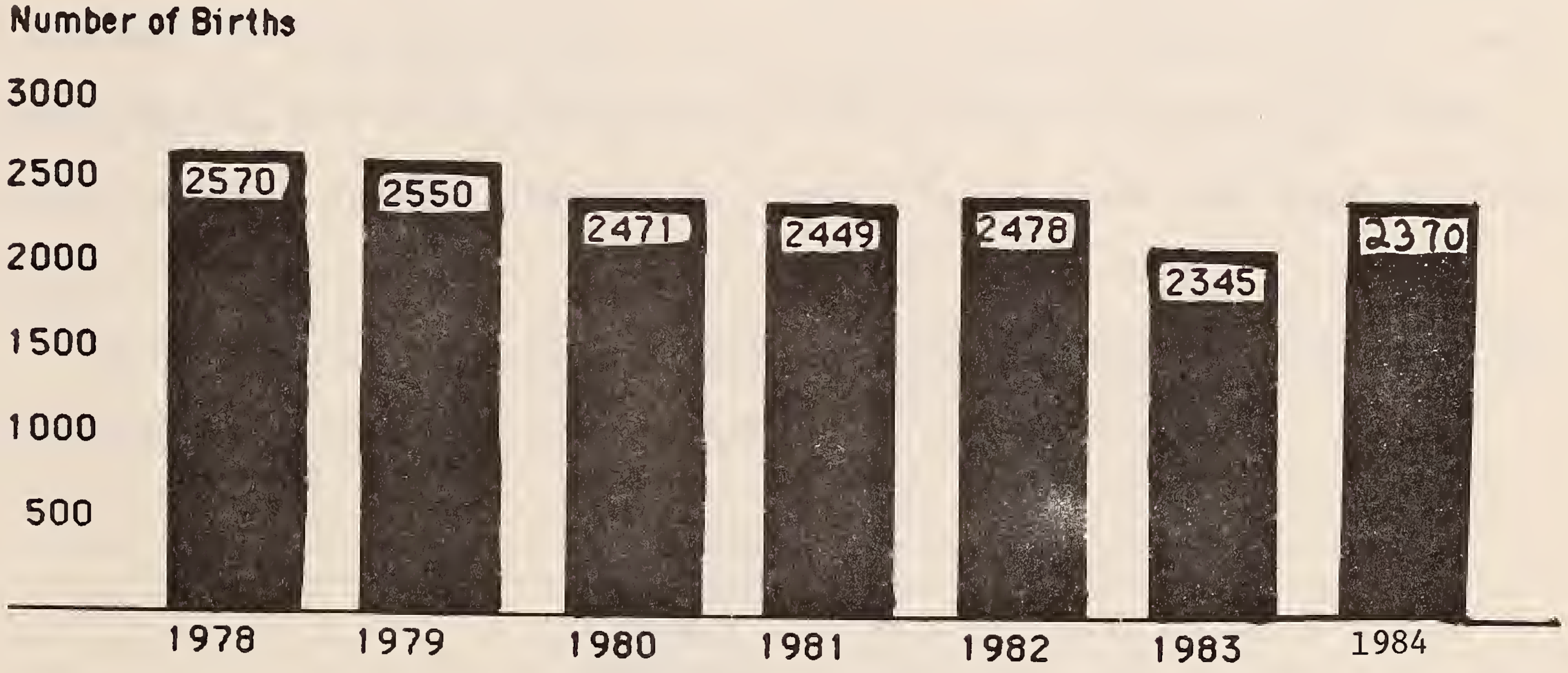
These figures should be viewed in the context of an overall decline in the female adolescent population, ages 15-19 years, in Massachusetts. In 1983, this population consisted of 245,266; in 1984, it decreased to 236,575 - 8,691 female adolescents less than the previous year. (Based on provisional populations, see table three) In 1983, 2.8% of the female teen population, ages 15-19 years, gave birth; in 1984, 3.0% gave birth. Of the total births to teens in 1984, ages 15-19 years, 1,126, or 16% were repeat births to mothers already having at least one child. In 1981, the teen birthrate in Massachusetts for ages 15-19 years, was 28/1000; in 1983, the birthrate decreased to 27.8/1000. In 1984, the birthrate increased to 29.3/1000, the highest in recent years.

According to yearly statistics from the Mass. Dept. of Public Health, Division of Health Statistics and Research, of teenage births in Mass., over the five year period of 1980 to 1984, teenagers gave birth to 36,490 babies. Many of these were repeat births to teenage mothers who already had at least one child. Cumulatively, thousands of these young mothers leave school, become economically dependent, and they and their children live in poverty. Currently,

in Massachusetts, there are approximately 15,400 teenage mothers. Many of these young mothers have more than one child. This means that approximately 7% of the teenage population in Massachusetts are young mothers.

Increases in births to teenagers in 1984 occurred in both school-age and in older teen categories. Of the total increase of 97 births to all ages of teens, there were 72 births to older teens, and in younger teens, up to 17 years, there was an increase of 25 births. The following table indicates fluctuations in births to teens up to 17 years old, from 1978 to 1983. Figures have been added for 1984.

Births to Minors (under age 18), Massachusetts, 1978-1984



Data Source: Dept. of Public Health: Division of Health Statistics and Research
Alliance for Young Families: "Uncertain Futures: Massachusetts' Teen Parents and Their Children", 1984 30

The following is a comparison between 1983 and 1984 of teenage births by age:

Age of Mother

	12	13	14	15	16	17	18	19	Total
1983	0	8	78	255	726	1278	2053	2521	6,919
1984	9 (combined)		75	265	714	1307	2061	2585	7,016

Data Source: Mass. Dept. of Public Health: Division of Health Statistics and Research

According to a recent report from the Department of Public Health, Division of Family Health Services, from the study, Massachusetts Adolescent Pregnant and Parenting System (MAPPS), of all births to teens ages 15-19 years in 1984, 5,449 were first births, 965 were second births, 145 were third births, 12 were fourth births, and 2 were fifth births.[31] Of the total of 84 births to teens 13 and 14 years, 76 were first births, 1 was a second birth, and 1 was a third birth.

In a 1985 report from the Alliance for Young Families, the five top cities in births to teens who are minors (12-17 years) in 1982 were:[32]

Boston	521
Springfield	190
Worcester	113
Lawrence	78
Brockton	76
Fall River	76

Recent statistics indicate that there have been increases and decreases in the number of births to minors, in some cities, and that some cities have replaced others.

The top five cities in births to teens who are minors for 1984 were:[33]

Boston	438
Springfield	198
Worcester	101
Lawrence	101
Lowell	92
New Bedford	79

A list of the top 25 cities and towns in Massachusetts in teen births of all ages, and the percent of these teen births for each city and town to total births is in table four. Table five gives the ranking of cities and towns by numbers of births to teens in each health service area of Massachusetts.

The top twelve cities and towns in Massachusetts in 1984 in the percent of teen births to total births for that city or town are:

Winchendon	(25-110)	22.7%
Springfield	(504-2612)	19.2%
Lawrence	(246-1303)	18.8%
Holyoke	(141-749)	18.8%
Southbridge	(44-250)	17.6%
Fall River	(234-1380)	16.9%
Spencer	(27-167)	16.1%
North Adams	(39-244)	15.9%
Wareham	(39-245)	15.9%
New Bedford	(232-1473)	15.7%
Northbridge	(29-195)	14.8%

The figures on the left side of the parentheses are the number of teen births; the figures on the right are the number of total births of all ages.

According to the Guttmacher Institute, in 1981[34] the birthrate for Massachusetts cities were as follows, for teens ages 15-19 years:

Lawrence	80 per 1,000
Holyoke	77 per 1,000
Springfield	66 per 1,000
Fitchburg	62 per 1,000
Fall River	60 per 1,000
Lowell	57 per 1,000
Boston	54 per 1,000

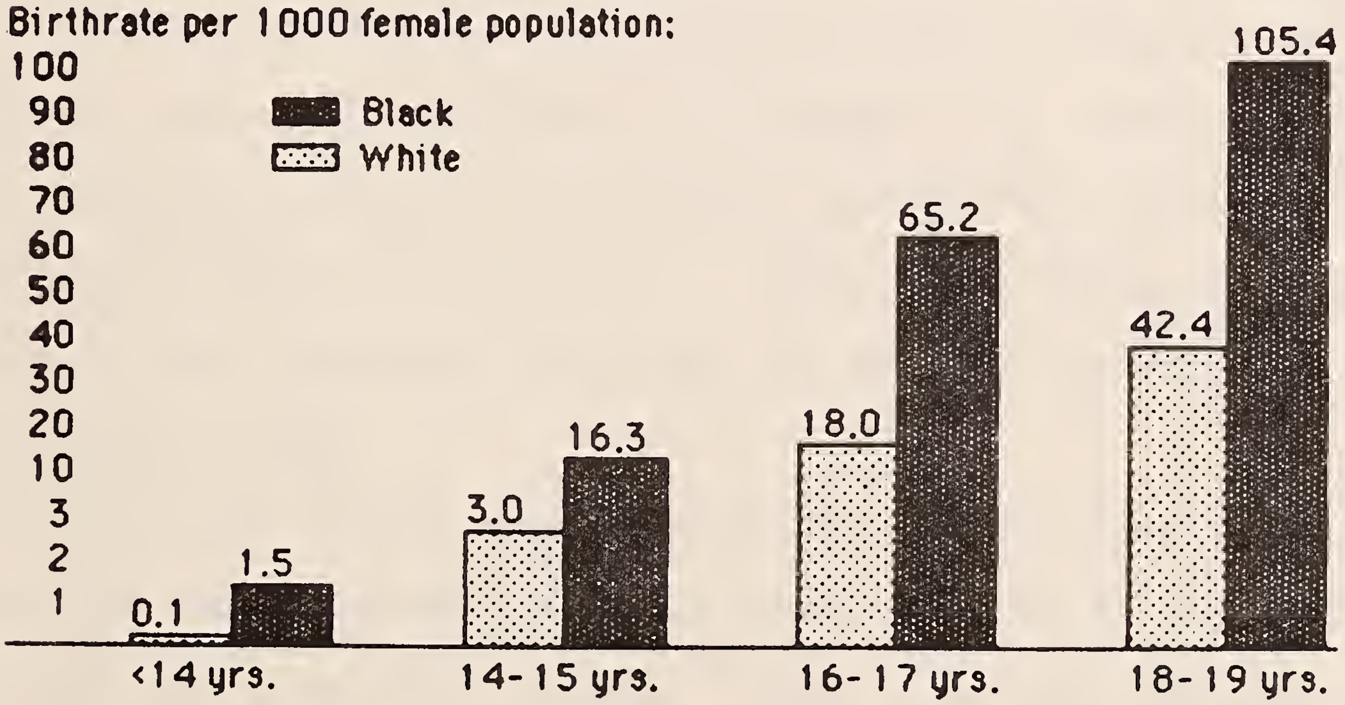
The report from the Alliance for Young Families stated, "while the number of black mothers is less than 13% of all teenage mothers in the state, the actual birthrate among black teenagers is 2-3 times higher than it is among white teenagers." The following tables give the number of teen births by maternal age and race for 1983 in Massachusetts, and the age-specific and race-specific birthrates among teens, black and white in Massachusetts in 1980.

Number of Teen Births by Maternal Age and Race, Massachusetts, 1983

Race	**Minors (under 18)**	**18-19 years**	**Total teen births**
White	1581	3608	5189 (74.9%)
Black	380	501	881 (12.7%)
Hispanic	306	357	663 (9.5%)
Other	26	35	61 (.88%)
Unknown	52	73	125 (1.8%)
Total all races	**2345**	**4574**	**6919**

Data Source: Alliance for Young Families: "Uncertain Futures: Massachusetts' Teen Parents and Their Children", 1984
Dept. of Public Health: Division of Health Statistics and Research

Age- and Race-Specific Birthrates Among Teens, Black vs White Teens, MA, 1980.



Source: Mass. Dept. of Public Health, Division of Health Statistics and Research

In 1984, of the 7,016 total births to teenagers in Massachusetts, 5,766, or 82%, were to white teenage women. Of the same total births to teens, ages 13-19 years, 1,043, or 14.8% were to teenage women who were black, Hispanic, and other race/ethnic groups. Births by age, race, and marital status for 1984, are presented in table six.

PREGNANCY RATES

In 1981, among teenage women ages 15-19 years, the Guttmacher Institute stated that the Massachusetts pregnancy rate was 69 per 1,000. In 1983, the teen pregnancy rate for this age group was 61.1 per 1,000.* About 15,720 teenage women became pregnant in 1983; in 1984, about 14,450 teen women ages 15-19 years became pregnant.** While the pregnancy rate has declined (also the total female adolescent population in that age group has declined), the birthrate has increased by 1.5 per 1,000.

In 1983, teen women ages 13-19 years had 8,881 abortions. In that same year, school-age teens, 13-17 years had 2,672 abortions. Teen abortions ages 13-19 years accounted for 23.8% of all abortions for that year. School-age abortions accounted for 14.5% of all abortions. In 1984, teen abortions for ages 13-19 numbered 7,522, a decrease*** of 1,359. Teen abortions accounted for 23.5% of all abortions in 1984.

Of the 15,720 teenage women, ages 15-19 years, who became pregnant in 1983, 55.2% had an abortion and 43.4% gave birth. Of the 14,450 teenage women, ages 15-19 years, who became pregnant in 1984, 50.6% had an abortion, and 47.9% gave birth. Between 1983 and 1984, more teenage women gave birth, and fewer teenage women had an abortion. Age breakdowns of teenage abortions for 1983 and 1984 are given

* Based on approximations for provisional population counts and miscarriages and stillbirth approximations.

** Figures must be weighed with the fact that it is almost impossible to determine total pregnancies as not all miscarriages are reported.

*** Abortion numbers may be influenced by more or less reported numbers year by year.

in tables seven and eight. Comparisons of births and abortions for the five year period of 1980-1984, for teenagers 13-19 years, are presented in table nine. Comparisons of births and abortions for the five year period of 1980-1984, for school-age teenagers, 13-17 years, are presented in table ten.

Research studies express concern, along with professionals and others working with adolescents, that early abortions can leave long-term, negative physical, social, and psychological consequences in the lives of adolescents having them.

PROFILE OF PREGNANT AND PARENTING TEENAGERS

Who are the young mothers and their children behind these statistics and figures? It has been consistently documented that teenagers with low self-esteem, low school achievement, and low aspirations are more likely to become pregnant, and to become young mothers. Many experience a lowered socioeconomic status, family problems, and a sense of alienation. Many feel a sense of fatalism and passivity, and think that life offers them few options and opportunities, apart from getting pregnant. This is especially prevalent among adolescents living in poor homes, or who are themselves poor. Many young women perceive that for themselves living trapped in poverty, life offers them few realities that are attainable for them, or that they can aspire to, apart from having a child. Giving birth, for many of them, is viewed as a "way out", or as something to give them a sense of fulfillment that is lacking in the rest of their lives. According to research from "Private Crisis, Public Cost"[35], regarding motivational factors in teenagers, "while a service provider, policy maker, or research team may select only one or a few factors for concern, it should always be kept in mind that these factors represent part of a complex process with numerous determinants operating consecutively or simultaneously, together or in opposition, helpfully or harmfully, rationally or irrationally, among some individuals but

not others, and that some are far harder to change than others." Also, from the same source, "many teenagers who become parents have multiple problems themselves (e.g. school failure, drug or alcohol abuse, depression), and some come from multiproblem families".

With many young women who become pregnant, there is often a history of feeling deprived and neglected. Many have been abused as children, and many are still being abused.[36] For many others, having a child is an attempt to get their own security and nurturing needs met. For others still, high school seems pointless and removed from their realities, and is not seen as a first step towards self-sufficiency, nor as something in which they can succeed and is attainable.[37]

Many research studies have consistently shown that teenage women who become pregnant do not do so in order to get handouts, or to become dependent on public assistance. Nor do they become pregnant in order to move away from home, and "get a place of their own", at public expense. These motivating factors are often attributed to pregnant and parenting teens, and have been repeatedly refuted in research literature in this area. Many young women become pregnant unintentionally. Many others feel that having a child is a viable option to what their lives are, while others see having a child as the only option left open to them. Young teen males and females often lack the adequate and accurate information regarding sexuality and conception.

In both rural and urban areas young women perceive a definitive lack of opportunity in their lives, and an absence of interesting and motivating alternatives to childbearing. They feel "locked into their stations in life".[39] Needy teenage women think that having a baby will fill a void in their lives, and help give them direction and purpose. They feel a sense of hopelessness and resignation, and do not perceive that they are placing their infants and children

at risk for a repeat of the same pattern as their own lives. Many become pregnant again within a short period of time after the first birth. Many have hopes of escaping a dreary existence and of finding direction and purpose to their lives. Instead many sink into heavy responsibilities and demands for which they are unprepared, and have not reached the level of maturity necessary to take care of the consequences of bearing children too early in their lives. For many, their lives become out of control, and they become entrenched in a generational cycle of poverty.

There is a continuum of needs and motivational factors* that have been cited consistently from research in this area.[40] For some, childbirth is perceived as an attempt to gain some independence from their families. For others, it is felt that having a child will give them a sense of being needed and loved. For still others, childbearing is seen as a validation of an adult role. Many are immature and inexperienced, which affects their thinking processes. Some teens lack the abilities to assess accurately themselves and their environment, to plan ahead, to anticipate the consequences of their actions, or to develop realistic expectations. Teens are generally thought of as being "risk-takers", and as entering their life experiences on a trial and error basis. Young teens, and even older teens, vascillate between seeking independence, and in needing some forms of dependence. Their behavior tends to fluctuate widely, and they are constantly striving for identification and self-esteem. More in-depth analysis of teenage attitudes, motives, and behaviors regarding teenage pregnancy, is stated in table eleven.

FATHERS OF CHILDREN OF TEENAGE MOTHERS

There has been a long-term lack of information about and studies done on the fathers of infants and children born to teenage mothers. Some literature refers

* see table eleven

to these fathers as the "missing father myth",[41] meaning that there is an assumption, often incorrect, that these fathers are not present after the birth of the child, or during the pregnancy, and are not generally part of the lives of the mother or the child. Some recent studies have shown that frequently this is not the case, that young fathers do want to contribute financially and with support, and do want to take some of the responsibility, and be part of the life of the child. Some young fathers do become alienated from the mother, the child, and the family of the mother; many are in the lives of the mother and child, or children, only marginally. But many are available, and do contribute what they can. Unfortunately, many of the young fathers also drop out of school, and work in underpaying jobs, or become unemployed themselves. Most do not have the resources, emotionally, socially, or financially, to help in any substantial ways, but do make some attempts.

Research shows that many young men go through the same emotional struggles and confusions as the young mothers do, and are experiencing the same difficulties within themselves. Young fathers have many of the same needs as the young mothers do. Teenage fathers, or older men who father the children of teen mothers, often want the babies as much as the teen mothers do, for many of the same reasons. For both, having a child may seem to be something in their lives that is truly theirs. Since many of these parents do poorly in school, and in other aspects of their lives, having a child is an accomplishment. For many who come from troubled homes, a baby can be the first human from whom they can receive love.

Research shows that many fathers usually do not marry the teen mother, but often continue to date her through the baby's first years. Many fathers do want to help support both mother and child, and want to contribute as best they

can and according to their own abilities. In one study conducted by the Department of Human Services at the University of North Carolina, findings from a survey of 26 male parents between 16 and 21 years stated that 22 believed they had responsibilities towards the mother and baby, and 18 of the fathers saw the mother and child at least once a week.

The fathers of the babies of teen mothers, whether they are themselves teenagers, or older men, often face hostility from the mother's family. Young fathers are often left out of decisions that are made about their babies, mostly by the mother and her parents. Often, fathers are not even told when the baby is born, or that the child has been placed for adoption or for foster care placement.

While many young fathers may be eager to help and contribute during the first few months, or even years of the baby's life, gradually they become overwhelmed by the unexpected medical, clothing, food, and other needs, and their financial contributions cease or dwindle to a small amount.

There are recent studies indicating that many fathers - some estimates are as high as 50% - of the babies of teen mothers are not themselves teenagers. Some studies indicate that often the fathers are several years older than the teen mothers. This is an area of current research, and one that must be carefully considered for it's implications and impact.

SEXUAL ACTIVITY, MEDIA, PEER, AND FAMILY INFLUENCES

In the United States, estimates are that about 50% of all young people between the ages of 15 and 19 are sexually active.[42] Of all teenagers 13-17 years, 3.5 million males and 2 million females are sexually active.[43] For ages 13-19 years, estimates are that there are 7 million sexually active male adolescents, and 5 million sexually active female adolescents in the United States.[44] Of the 15 million teens who are not sexually active, estimates are that over one-half

will become sexually active by the time they reach age 20 years.[45] According to the Center for Population Options, 41% of all teens have had sexual intercourse by age 19 years. From research at Johns Hopkins University, Social Research Institute, results of a survey study done with teenage women show that one out of every five 15 year olds admitted to being sexually active; 1/3 of all 16 year olds admitted sexual activity, and 43% of all 17 year olds admitted to being sexually active.

Sexual activity among teenagers up to 19 years increased by two-thirds between 1970 and 1980.[46] Teenage males and females are now maturing sexually at an earlier age. The age of sexual maturity is currently held at between 12 and 12-1/2 years old.[47]

While teens represent 18% of sexually active women capable of becoming pregnant, they account for 46% of out of wedlock births, and 31% of abortions in the U.S.[48]

According to the Guttmacher Institute, among those teens who are unmarried and ages 13-14, 18% of the males and 6% of females are sexually active. Of those teens who are unmarried and ages 15-19 years, 56% of males and 41% of females are sexually active.[49]

According to the Children's Defense Fund, adolescents are "risk takers". While teens are under pressure from peer influences to become sexually active, this is coupled with the fact that admission of sexual activity is not acceptable in the larger society in which they live.

Adolescents often perceive themselves as invincible and think that "bad things happen", but not to them. Teens are more likely to perceive that "sexual activity without contraception is only likely to result in pregnancy".[50] Pregnancy as an outcome is not certain, and teenagers may therefore reinforce this thinking in themselves and focus on this distinction. They are able to

convince themselves that pregnancy cannot happen to them. According to a report in "Youth Law News" on teenage pregnancy,[51] "discussion of the 'issue' of teen pregnancy is prevalent in the media. However, public acknowledgement and discussion of teen sexuality has not accompanied the recognition of teen pregnancy. Consequently, admitting sexuality may be seen by teens as less acceptable than having a baby."[52]

Accompanying the rise in the numbers of teenagers who have become sexually active, have been the increasing numbers of teenagers who become pregnant. However, increased and more consistent use of contraception has not kept pace with this increase. While accessibility and availability of birth control has expanded, many teenagers become sexually involved for many months before ever using contraceptives; many, in the meantime, become pregnant. "Sexual activity often comes well before a teen's personal acceptance of herself or himself as a sexual being. Consequently, the average teen is sexually active long before seeking contraceptive advice and use."[53] According to recent research studies, the average teenager waits from between 12 to 17 months before using any contraceptives at all, or seeking any advice.

In a survey conducted in 1982 on high school students,[54] 27% said they never used any method of birth control; 39% said they sometimes used a method of birth control; 34% said they consistently used a method of birth control.

Studies indicate that more teenagers are practicing contraception, and are doing so more consistently, and earlier than they were previously. However, these same studies indicate that they are increasingly using ineffective methods. "Most teenagers, approximately two-thirds, don't use even ineffective methods of birth control on a regular basis, or never use any method at all."[55] In 1980, a study of 1200 teenagers who had never been pregnant or sought professional

birth control advice were surveyed when on their first visit to a family planning clinic. The average interval between becoming sexually active and seeking contraceptive advice was 17 months. More than one-third of this group were at the clinic because they feared they were pregnant.[56]

The reasons given by teenagers themselves for inconsistent use or lack of use of contraception suggest that family planning clinics, along with education, hold part of the answer to the problem. When asked why they had delayed seeking birth control, many said that they just didn't get around to it. Others said they feared that their families would learn of the visit. The survey indicated that teenagers experience a large amount of misinformation and fear, and these are factors that often deter them from seeking contraception services and advice.

According to a report from the Urban Institute in Washington, D.C., "family planning clinics serve significant numbers of sexually active teens, mostly low-income or marginally above poverty, all of whom obviously have some motivation to contracept effectively. They miss approximately half of the relevant female teen population. They miss virtually all of the relevant teen male population, and efforts of these clinics to involve teen males have met with very little success."[57]

According to the Guttmacher Institute, "teenagers know dangerously little about conception and contraception. Forty-one percent of unmarried teens who have never used contraception reported not using it because they thought they could not become pregnant. In another survey, only four in ten teenagers know when a young woman can become pregnant.

The Center for Population Options estimates that an average television viewer sees 9,230 scenes of suggested sexual intercourse, sexual comment, or innuendo during the course of a year. Yet, references to birth control are rare.

"Teenagers watch about 24 hours of TV each week. By the time they graduate from high school, they have spent more time watching TV than being in school."[58] Teenagers also listen to the radio for approximately 21 hours each week. In a survey of 1,400 parents of children ages 3-11 years, TV ranked second only to parents as the primary source of their children's learning. Another report states that "media ranks third, behind peers and parents, in influencing the values and behavior of teens. This represents a dramatic shift since 1960 when the media ranked eighth behind such factors as teachers, relatives, and religious leaders."[59] Still another report states that TV portrays six times more extra-marital sex than sex between spouses. About 94% of the sexual encounters on soap operas are between people not married to each other. Much of the research states that the media influence is one that propels still-immature pre-adolescents and adolescents toward precocious sexuality, and that premarital sex appears to youth as now being "conventional".

Many studies suggest that if communication about sexuality within families was improved, irresponsible sexual behavior and unwanted pregnancies can be reduced. When asked what their sources of information about sexuality in one study, 37% of the teenagers stated that they were influenced by peers; 22% stated literature; 17% said their mothers; 15% said their fathers; 8% were other sources.[60] Some studies project the sense that the message to teenagers from the media is a double standard, and creates ambivalence and confusion in teenagers. The message they perceive is that unprotected sex is bad, but that sex should be sought after and pursued. In part, this message may be reinforced by parents who have difficulties admitting that their teenagers are sexually active.

Public opinion polls taken by the Center for Population Options and the National Association of Broadcasters[61] indicate that 80% of adults support the

use of public service announcements and 75% support the use of television news broadcasts to disseminate information about birth control.

In a study conducted by researchers at Johns Hopkins University[62] on the influence of peers and families on sexual behavior, contraceptive use and pregnancy experience, results showed that teenagers whose views resembled that of their parents had low levels of premarital sexual experience; those resembling their friends' views had high levels of premarital sexual experience. Many of these teens were frequent users of contraceptives, but few had consistent use. Also, the sexual behavior of adolescents is generally consistent with that of their peers, and that peers are a more likely source of contraceptive information than parents for most teenagers.

Results from a Harris Poll conducted nationwide in August, 1985, indicate that 84% of parents interviewed stated that they think teenage pregnancy is a serious problem; 64% of the parents believe they have little or no control over teenage sexual activity; 52% of the parents believe that parental consent should be required for teens to receive health services, treatment, prescriptions, etc.; 87% of the parents supported sex education in the schools; 69% favored school links with family planning services. The survey also stated that only 10% of the nation's school-age children and youth receive comprehensive health education and services. In a 1985 survey conducted by an independent agency for Time, Inc., 78% of those surveyed favored sex education in the schools, including information on birth control.

While there is no certain way of determining how many teenagers are sexually active in Massachusetts, studies by the Department of Public Health[63] state that the number of family planning visits by teenagers across the state to clinics, gives some idea and can be used as a determinant. In 1980, 13,597

youth under 18 years visited family planning clinics; 14,231 18 and 19 year olds visited clinics. In 1983, 15,791 youth under 18 years visited clinics, and in that same year, 16,923 18 and 19 year olds did. In 1984, participants in the Massachusetts Adolescent Pregnancy and Parenting Study were asked about their use of contraceptives. Of those responding, 8.71%, or 101 stated that they always use contraceptives; 28.56%, or 331 stated that they sometimes used them; and 62.83%, or 727, stated that they never used contraceptives.

From another report on Massachusetts,[64] in 1984, teenagers represented 36% of all family planning clients for services, or 31,071. The unmet need for services to teenagers was stated as 66,559. The Department of Public Health, Massachusetts Pregnant and Parenting Study indicates that 14,707 of these were less than 18 years old, and 16,364 were 18 and 19 years old. These figures do not include visits to private physicians, or to hospital gynecological clinics. Figures must be added to family planning visits of those teenagers who become pregnant, experience a miscarriage, stillbirth, abortion, or birth, when determining those teenagers who are sexually active.

According to a 1985 report from the Department of Public Welfare,[65] "while use of family planning agencies by adolescents is growing, the proportion of sexually active teenagers that receive family planning services is still very small. It has been estimated that more than 190,000 adolescent girls, and a similar number of boys, are sexually active. Although this statistic indicates that three times as many teenagers are utilizing such services as in 1975, it still means that roughly nine out of ten sexually active teenagers are not benefiting from family planning services."

HEALTH CONSEQUENCES OF EARLY PREGNANCY AND PARENTING

Teenage pregnancy and childbirth are a more serious health risk than

they are for women over 20 years. Also, teenagers who become pregnant and give birth early in their teen years are likely to have twice as many children as do older women, thus causing further risks and potential complications. Teenage mothers have twice the normal risk of complications at delivery than do older women. Pregnant teenagers are 15% more likely to have toxemia, 92% more likely to have anemia, and are 39% more likely to have complications related to premature births.

A recent Massachusetts report stated,[66] "complications of pregnancy and delivery, low birthweight, and infant mortality are associated with poor nutrition, smoking, substance abuse, and inadequate prenatal care. Pregnant teenagers, as a group, have one or more of these characteristics with predictably poor outcomes for the newborn and the mother.

This same report stated, "maternal and child health status among minority populations is poorer than that of the general population, in large part due to restrictions on access to health care because of cultural, racial, and economic barriers. Much of the difference in health status between whites and minorities can be explained by economic variables."[67] For those individuals and families whose incomes are at or near the poverty line, the maternal and child health risks are even greater. Many of those who are most at risk, are teenagers and their children.

Prenatal Care

Results of a survey conducted in 1984 of all fifty states[68] indicated a definite shift away from early prenatal care to late or no prenatal care among pregnant teenagers. It has been consistently documented that babies born to women receiving late or no prenatal care are three or more times as likely to die in infancy as those receiving early care.

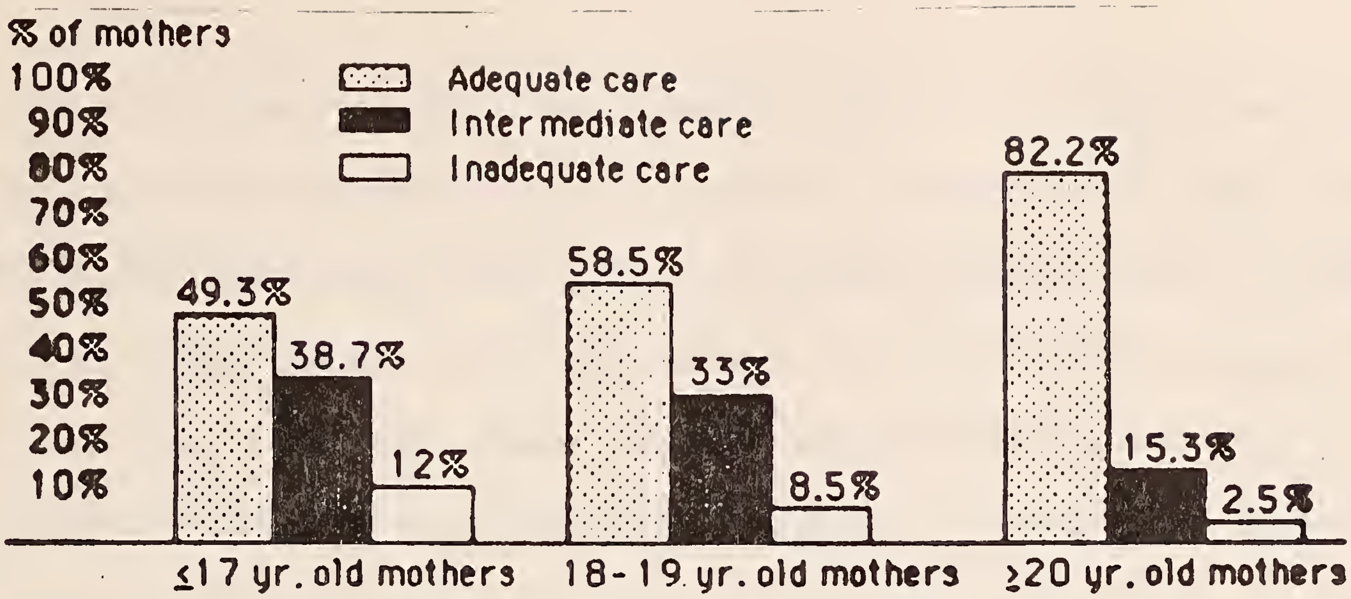
A national study on the prevention of teen pregnancy[69] states, "young mothers are the most in need of comprehensive prenatal care, yet are the least likely to receive early care during pregnancy." This same study states that in 1982, 75% of all babies were born to women who received care in the first three months of their pregnancy. Yet, only 54% of babies born to women under age 20 had mothers who received early care. Inadequate care places young women at increased risk of delivering low birthweight babies.

During the first three months of pregnancy, 56% of teens do not receive prenatal care; for pregnant teens under 15 years, one in five receives late or no prenatal care, according to a national report.[70] From this same report, nearly 40% do not receive any prenatal care until the third trimester of their pregnancy.

According to national data, for white teenagers, ages 15-19 years, 57% receive early prenatal care. For black teenagers in the same age group, only 47% receive early care.[71] For those pregnant teenagers under 15 years of age, 32% of black teens receive prenatal care in the first three months; 36% of white teens under 15 years receive prenatal care during the same time period. For pregnant teens ages 15-19 years, one in seven black mothers and one in ten white mothers receive little or no prenatal care.

A recent Massachusetts report from the Alliance for Young Families states, "teen mothers are less likely to receive adequate prenatal care than mothers age 20 years and older. In 1983, only 49.3% of teen mothers under the age of 18 and 58.5% of 18-19 year olds received adequate prenatal care as compared to 82.2% of mothers 20 years and older. Less than adequate prenatal care is a contributing factor to low birthweight babies."[72]

The following table represents the proportion of mothers receiving adequate, intermediate, and inadequate prenatal care in Massachusetts in 1983.



*Note: Inadequate care also includes no care.
Adequacy of care defined as number of visits by trimester of registration, adjusted for gestational age.

Source: MA Department of Public Health, Division of Health Statistics & Research.
Alliance for Young Families

From a study in 1985 on Project Good Health by the Department of Public Welfare, quoting the Department of Public Health, "pregnant teens are four and one-half times as likely not to have prenatal care as older women, and, as a result, are more than one and one-half times as likely to have low birthweight babies."[73]

In a 1986 report from the Department of Public Health's MAPPS program with teenage mothers, 51.4% of the mothers participating in the study received prenatal care in the first trimester, 36.3% received care in the second trimester, and 11.0% in the third trimester, in 1984. No prenatal care was received by 1.3% of these mothers. A list of cities and towns in Massachusetts with percentages of those teenage women receiving adequate prenatal care in 1984, is presented in table twelve. A breakdown of adequacy of care by ethnicity is presented in table thirteen. Table fourteen states the birth outcomes for teen births by adequacy of care, using the factors of low birthweight, maternal complications, and infant complications.

There are many studies that correlate high risk of birth complications to teenagers, and the inadequacy of, or lack of, prenatal care, with poverty and the affordability and/or availability of adequate health care for them and their children. Those who are especially at high risk are black teenagers, the poor, and very young teens who become pregnant and give birth. The barriers to receiving adequate prenatal care most often cited are : low income, poverty, unemployment, and underemployment, lack of insurance for maternal care, lack of transportation, and other factors that are linguistic, cultural, attitudinal in nature. A crucial factor is that comprehensive prenatal care is not equitably available in all parts of the state.[74]

Many low birthweight births could be prevented and infant mortality rates reduced if teenage mothers were receiving the proper prenatal care. A report from the Statewide Task Force on Preventing Low Birthweight and Infant Mortality states, "babies born to women who had no prenatal care are ten times more likely to die within a month of birth and five times more likely to be seriously underweight than infants born with adequate care."[75]

The following table states percentage of births receiving late or no prenatal care, by age and race of the mother, in Boston for the years 1979-1982.

PERCENT OF BIRTHS WITH LATE OR NO PRENATAL CARE IN BOSTON
BY MOTHER'S RACE AND AGE

Age	Year	White	Black	Hispanic	Other	All races
≤ 17	79-80	32.9	35.3	23.6	DNA	33.0
	81-82	27.4	38.5	26.4	DNA	33.7
18-19	79-80	19.9	27.0	21.2	30.0	23.7
	81-82	26.3	29.5	18.8	35.0	26.6
20-34	79-80	7.9	16.2	15.3	14.7	11.5
	81-82	7.9	16.4	13.1	21.6	11.8
35 ≥	79-80	9.2	21.3	17.0	32.4	14.7
	81-82	9.6	13.4	16.7	20.4	11.8
All ages	79-80	9.7	19.8	17.3	17.3	14.3
	81-82	9.4	19.8	15.8	22.2	14.3

Source: Boston Department of Health and Hospitals, *Health Perspectives, 1981 and 1982*

Teen Mothers: Physical and Mental Health

Teenage mothers are more likely to die of pregnancy-related health complications than are older mothers. The maternal death rate for younger teens giving birth are two and one-half times the rate of older women.

In the United States, 10 out of every 25 pregnant teenagers deliver their babies by cesarean birth. The rate of teenagers under 15 years having cesarean births in 1984 in Massachusetts was 17.9 per 1,000; for those teenagers 15-19 years, the rate in the same year was 14.2%. Teenagers under 15 years had 15 cesarean births in 1984 - all primary births. Teenagers 15-19 had a total of 985 cesarean births in 1984, 870 being primary, and 115 being repeat cesarean births. Of the 7,016 births to teenagers in 1984, 1,000 were cesarean births, or 14% of all teen births in that year.[76]

Many teen mothers, and teenagers who become pregnant, are also involved in drug and alcohol use and abuse during their pregnancies and after the births of their children, thus passing on many health complications to their infants and children.

Results from the Department of Public Health's MAPPS study indicate that of the 2,465 teenage mothers participating at intake, 26.9% had used alcohol, 16.8% had used marijuana, and 4.8% had used other illicit substances. Of the 1,478 participating at the birth of their child, 27.2% stated they used alcohol and 21.5% said they had quit; 13.6% had used marijuana and 36.3% said they had quit; 3.4% had used other illicit substances and 46.0% said they had quit using. Of the 291 participating at the time their child was 18 months old, 46.7% stated they had ever used alcohol, 15.5% said they had used marijuana, and 6.5% said they had used other illicit substances. A further breakdown of substance use by teen mothers participating in this program, along with their

quit rates, is presented in table fifteen. A chart of substance use quit rates during the pregnancy of the teen mother, by ethnicity, is stated in table sixteen. Substance use quit rates were highest for the three categories of tobacco, alcohol, and marijuana, for black teens, with Hispanic teens second, and white teens third.

Teenage fathers and mothers are generally unprepared for the responsibilities of parenthood, and their offspring often suffer negative consequences. Teen parents tend to have unrealistic expectations of their children and immature ideas about what babies are like, and what to expect of them physically and emotionally. They may pressure their babies to do things devepmentally before they are ready. Sometimes these attitudes and behaviors on the part of young parents leads to impatience, intolerance, frustration, and feelings of inadequacy. This, in turn, can lead to increasing the potential for abuse and neglect. More than one-third of all child abuse cases involve families that began with a teenage pregnancy.

There has been multiple references in research studies indicating that many young women who experience pregnancy and childbirth in their early teen years, have been, and even continue to be, sexually abused as children. There are some estimates of the numbers of teens who become pregnant and have been sexually abused over a long period, that are as high as 60%-75%. More extensive and thorough research is needed in this area. During group sessions that have been recorded, or when teens have been interviewed, many young women admitted to having been sexually abused, usually by a member of their family, or a household member, or by a person who was in a caretaker's role during the teen's childhood years.

Low Birthweight Babies

In the United States in 1982, although births to teens were only 14% of all

births in that year, babies born to teenagers represented 20% of all low birthweight births. These babies are 20 times more likely to die than babies born at normal weight.[77] Over 17% of all births to teens under age 15 years in the U.S. are low birthweight births.

According to the Guttmacher Institute, low birthweight births are a major cause of infant mortality, and other childhood diseases, birth injuries, and neurological defects, including mental retardation.

Over 11% of all teenage live births, or 6.8% of all babies, will weigh less than 5-1/2 pounds at birth. Three-fourths of all infant deaths in the first 28 days of life and 50% of all infant deaths in the first year result in whole or part from low birthweight. One in four low birthweight infants will be left permanently disabled. Low birthweight babies are at higher risk of morbidity and mortality than normal birthweight babies.

Low birthweight and infant mortality rates are highest among the poor, teens, blacks, Hispanics, and poor whites. Infants born to poor women are one and one-half times more likely to die than those born to higher income women. For black infants, the death rate is twice that of white infants.[78]

In Massachusetts, low birthweight births account for two-thirds of the 700 infant deaths each year. Those who survive and are low birthweight, are at risk for medical and developmental disabilities.

According to several Massachusetts reports[79] there has been relatively little decline in the past decade in the rate of low birthweight births, an outcome known to be affected by prenatal care.

In a recent statement, Dr. Paul Wise, a pediatrician and Director of Perinatal Epidemiology of the Joint Program of Neonatology at Harvard Medical School said, "the survival of normal weight babies both during and beyond the

first month, of low birthweight babies after they leave the hospital, and the rate at which low birthweight babies are born in the first place, are all deeply affected by alterations in socioeconomic status.

The neonatal mortality rate in Massachusetts for low birthweight births in the period of 1979-1983 was 87.6 per 1,000 live births, as compared to 1.6 per 1,000 for normal birthweight.[80] The mortality rate for very low birthweight, under 1500 grams, is 419.9 per 1,000.

A report from the Department of Public Health[81] in October, 1985, states, "the areas (of the state) with the highest low birthweight rates generally rank high on other problem indicators as well, such as unemployment rates. The cities with the largest 5 year rates (1979-1983) are Boston, 8.6, Holyoke, 8.3, Springfield, 8.2, Worcester, 7.3, Brockton, 6.9 and Malden, 6.9. New Bedford,Taunton, Lawrence, Lynn, Fall River, Pittsfield, Cambridge, Chicopee, Haverhill, and Lowell also have rates in excess of the Massachusetts 5 year low birthweight rate of 6.0 births. These cities and towns also correspond to areas of the state with high numbers of teen births.

According to the Department of Public Health, there are higher rates of low birthweight in infant mortality for blacks and Hispanics in Springfield, Boston, and Holyoke.

Much of the statewide variations in low birthweight rates are the result of social and economic conditions.

In 1983, the low birthweight rate for blacks was more than twice the rate for whites, at 12.3 per 100 for blacks and 5.4 for whites. The 1982 rate for blacks was 11.6 per 100.

There are variations in low birthweight rates in Boston neighborhoods. In 1983, the low birthweight rate for Boston was 8.7, exceeding the state rate of

5.9. Several areas of Boston had exceedingly high rates at that time. The following chart gives the percent of low birthweight births in Boston by the age and race of the mother, from 1979 to 1982. Age breakdowns for low birthweight births are stated for teenagers.

PERCENT OF LOW BIRTH WEIGHT BIRTHS IN BOSTON
BY MOTHER'S RACE AND AGE

	1979-80	1981-82
Race		
White	5.6	6.0
Black	12.5	12.2
Hispanic	8.4	8.3
Other	5.7	5.4
Age		
≤17	13.1	11.8
18–19	10.6	10.5
20–34	7.8	8.0
35≥	8.5	8.9
Total	8.5	8.5

Source: Boston Department of Health and Hospitals, *Health Perspectives, 1981 and 1982*

The Alliance for Young Families stated in their report, "inadequate access to basic services, including health care, nutrition, and decent housing, often leads to poor health outcomes for the infant, as evidenced by the fact that school-age mothers are one and one-half to two and one-half times as likely as older mothers to have low birthweight infants."

In 1983, 13.2% of teens 15 years and under gave birth to low birthweight infants; 8.7% of teens 16 and 17 did; and 7.9% of 18 and 19 year olds did. In 1984, teen mothers gave birth to 627 low birthweight babies. This represents 13.6% of all low birthweight babies, and is an increase from 589 births that were low birthweight in 1983. In 1984, 16 of the teens less than 15 years old gave birth to low birthweight babies; 31 of the 15 year olds did; 90 of the 16 year olds

did; 122 of the 17 year olds; 174 of the 18 year olds; and 194 of the 19 year olds gave birth to low birthweight babies. In 1984, 8.9% of all teen births were low birthweight births, as compared to 8.5% in 1983.

Infant Mortality

Infant mortality rates are twice as high for young teens as they are for older women. In a statement in January, 1986, Marian Wright Edelman, President of the Children's Defense Fund stated, "we are concerned about increasing mortality among older infants, because deaths among babies between 28 days and one year are more likely to be caused by environmental factors such as poverty, poor nutrition, inadequate housing and sanitary conditions, and a lack of basic health care."[82]

In 1983, there were 682 infant deaths in Massachusetts, with an infant mortality rate of 9.0; 483 of these were neonatal deaths, for a neonatal mortality rate of 7.1. According to the Boston Committee on Access to Health Care, "the rate of decline in infant mortality has slowed in Massachusetts in recent years." Between 1981 and 1982, infant and neonatal deaths increased significantly. From the Department of Public Health, "the infant mortality rate rose from 9.6 in 1981 to 10.1 in 1982, which was the first increase in nine years and the largest increase in seventeen years. The neonatal mortality rate also rose from 6.9 in 1981 to 7.6 in 1982. The rates for 1983 suggest that the overall decline in the state rate as witnessed over the past decades is continuing. The 1983 Massachusetts infant mortality rate of 9.0 per 1,000 live births is lower than the provisional, national rate of 10.9 per 1,000 live births."[83] There are many complex factors behind infant mortality, neonatal mortality, and morbidity, such as poverty, stress, lack of, or inadequacy of prenatal care and overall health care, availability and accessibility to sufficient food and medical care, family structure and family life, and other such personal, social, economic, and environmental factors,

that influence the health of the mother and the birth outcome of the child.

The Massachusetts Infant Mortality Rates for the period of 1981 to 1984 are: 9.6 per 1,000 live births in 1981; 10.0 in 1982; 9.0 in 1983; and 8.9 in 1984, the lowest ever in the state.[84] In a Department of Public Health report entitled, "Towards the Prevention of Avoidable Illness and Premature Deaths", is stated, "rates in many urban areas, including Boston, also rose, and the infant death rates for blacks continued to be more than double those for whites (21.8 vs. 9.7). While rates in some communities in Massachusetts declined in 1982, communities such as Holyoke and Springfield continue to rank among the highest in the state." Infant mortality rates for 25 largest cities in Massachusetts for the period of 1979 to 1983, are stated in table seventeen.

Two-thirds of infant deaths are associated with low birthweight births. As teenagers, especially young teens, are more likely to have low weight babies, infant mortality rates are also high among teen births.

A May, 1985 report from the Department of Public Health's Task Force on Prevention of Low Birthweight and Infant Mortality states, "infant deaths and disability occur across the state in every racial, ethnic and age group, but gaps between groups can be identified. While rates of low birthweight and infant mortality have been declining among all racial and ethnic groups, the gap between rates for black and white infants has been roughly double during most of the past decade and appears to be widening. Rates for Hispanic infants appear to fall in between rates for these other two groups."[85] Other gaps identified by the Task Force are: rates for communities such as Springfield, Holyoke, and Boston exceed the state rate, and are more than double the rates for other communities in the state; babies born to poor women are 1-1/2 times more likely

to die than those born to women in higher income levels; rates for teenagers, particularly young teens, are consistently higher than those for older women.

In a recent testimony before a hearing on infant mortality, Dr. Paul Wise stated, "the persistence of social and racial disparity in the face of significant reductions in infant mortality deserves special attention. Data indicates that while infant mortality rates for all newborns has fallen, the relative disparity based on social status persist and in some areas have actually worsened. Our recent study documented a worsening picture for black infants relative to whites." Dr. Wise also stated that even the highly technical advances of modern medicine cannot erase "the legacy of larger social inequities which continue to shape the living social environment of children and pregnant women."

The Children of Teen Mothers

The children of teen mothers are often at risk for developmental disabilities, learning problems, and mental and physical difficulties. Frequently, teen parents are unable to adequately nurture their children, and need support systems that are often extensive. Also, "children of teens tend to have lower IQ's and school achievement scores, and are more likely to repeat at least one school grade. The cycle of family instability is often established."[86] Children who live below the poverty line, as many teenagers' children do, are more than twice as likely to be chronically undernourished as the general population. Health costs for undernourished children tend to be higher throughout their lives.

According to the Massachusetts Developmental Disabilities Council, "the personal, social, and economic toll of severe disabilities is very high. In many cases, heavy costs last over the course of a lifetime. Parents, families, and larger society all share the costs." Teenagers who have low birthweight and premature babies experience many of these problems with their children growing

up with some forms of developmental difficulties.

EDUCATION CONSEQUENCES OF EARLY PREGNANCY AND PARENTING

Of the total of all teen mothers in the United States, two-thirds have not finished high school. Over 10% have not finished the 9th grade, and only 1.6% have finished college. According to an article in Youth Law News[87] "only one-half of the women who become mothers before 18 years complete high school, as opposed to 96% of those who do not have a child until after 20 years of age. Teen fathers are 40% less likely to graduate from high school than are older fathers."

A report from the Urban Institute states, "many pregnant teens are already a year or more behind in school when they get pregnant, and many have already dropped out, officially or through truancy."[88] Only one in five high school dropouts is employed. Among mothers under age 30 years who were teen mothers, and did not finish high school, the poverty rate is 90%. Teen mothers earn about one-half during their lifetime, if they earn at all, of the income of those who remain in school, and delay parenthood.

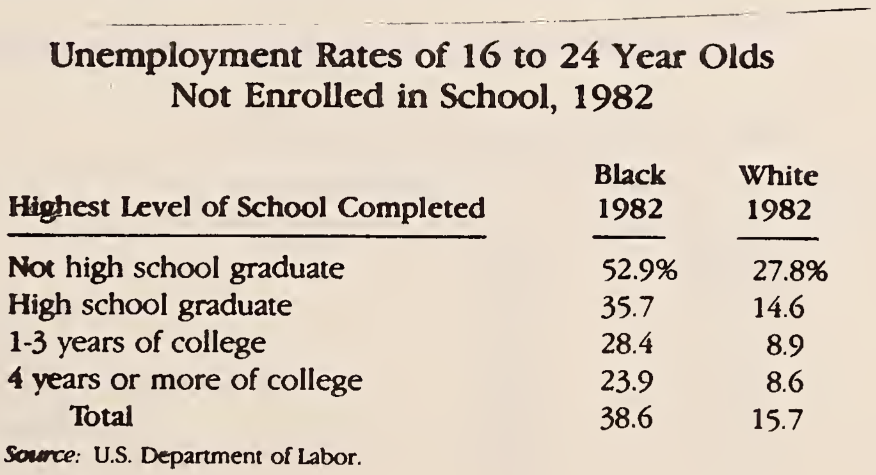
While the impact of early childbearing on school completion has been well documented, the impact of school completion on the probability of early childbearing has not been fully documented.

According to a recent report from the Rockefeller Foundation[89] "for the country as a whole, fully 25% of fifth graders do not make it through high school, and in urban centers, the rates are well over 50%. Research shows that half of the girls drop out because they are pregnant. Clearly, risk of pregnancy among those who are not yet mothers increases rapidly as they hit the streets and find almost no employment opportunities. Many of the young mothers, whether in school or out, give evidence of a severe lack of cognitive development and an inability

to make informed decisions about their future." This report stresses the necessity of schools needing to work with students long before they reach the level of alienation and failure that causes them to drop out and/or have babies.

A report from the Mott Foundation[90] states that one-third of all high school students in the United States are at risk of dropping out of school. Students at risk are defined as those students who are at least 14 years of age and who evidence poor grades, attention patterns, general disaffection with school, and who often require modifications in their instruction and other services. The most high risk students also have a high rate of absenteeism.

Dropouts are twice as likely to be unemployed as those who remain and complete high school. Minorities are three times as likely to be unemployed if they are dropouts. Those students with no more than an 8th grade education are three times as likely to be poor in adulthood as those with a high school education. Poor children and youth who are hungry, and may not be in good health, are more at risk at school and more likely to dropout. These figures have serious implications for pregnant and parenting teens, as nationally, 80% of pregnant and parenting teens drop out at some point. The following chart gives unemployment rates of 16-24 year olds not enrolled in school, by race, for 1982.



Unemployment Rates of 16 to 24 Year Olds Not Enrolled in School, 1982

Highest Level of School Completed	Black 1982	White 1982
Not high school graduate	52.9%	27.8%
High school graduate	35.7	14.6
1-3 years of college	28.4	8.9
4 years or more of college	23.9	8.6
Total	38.6	15.7

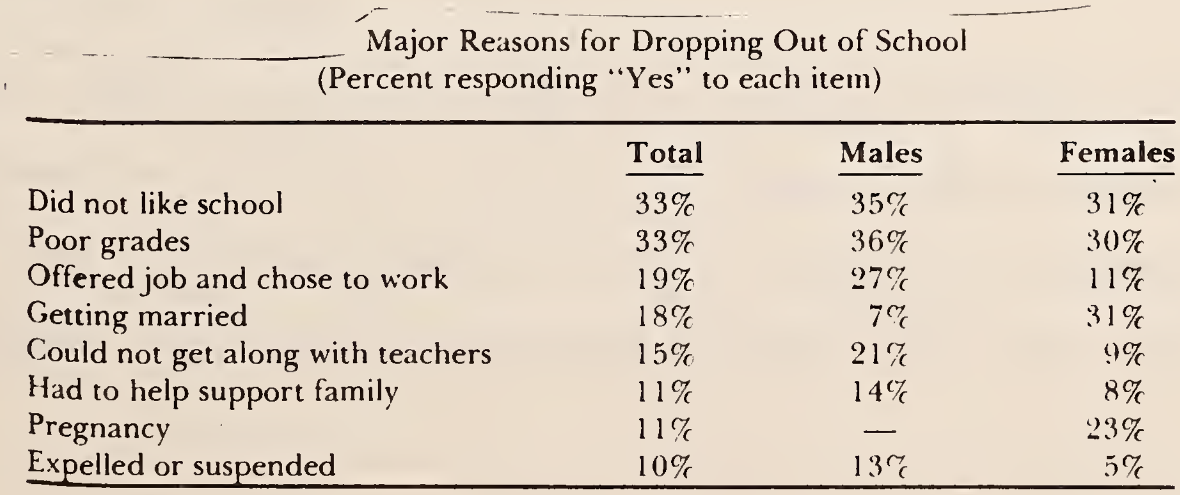
Source: U.S. Department of Labor.

Source: Children's Defense Fund, Preventing Children Having Children, 1985

A Rand report prepared for the National Institute of Education[91] states that once a teenager has decided to keep the baby, a decision must be made to stay in school, or leave. Unfortunately, many times this choice is made long before the school is informed, if it is informed at all, thus making intervention services and supportive help almost impossible. According to the report, "these decisions depend heavily on personal motivation and peer and family pressures." The role of school personnel in identifying high risk students, and helping marginal students make informed choices about what options are available to them is critical in dropout prevention, or in retrieving students who have already dropouts or who have a high rate of absenteeism.

Again, from the Rockefeller Foundation report, "school retention must receive high priority as an intervention to prevent early childbearing. Such schooling must be of the calibre that children are given a sense of self-esteem and elevated aspirations, and are allowed to develop the skills necessary to achieve this aspiration. The more highly motivated the girl is in regard to further education and career, the less likely she is to consider being a teenage parent."

In 1983, the National Center for Education Statistics contracted with Educational Testing Service to conduct a study on why students drop out of school. The following table summarizes these reasons:[92]



Major Reasons for Dropping Out of School
(Percent responding "Yes" to each item)

	Total	Males	Females
Did not like school	33%	35%	31%
Poor grades	33%	36%	30%
Offered job and chose to work	19%	27%	11%
Getting married	18%	7%	31%
Could not get along with teachers	15%	21%	9%
Had to help support family	11%	14%	8%
Pregnancy	11%	—	23%
Expelled or suspended	10%	13%	5%

Source: Teachers College Record, Vol. 87, No. 3, Spring, 1986

In Massachusetts, estimates are about 50-60% of teen mothers drop out of school and become economically reliant on public assistance programs. Using the current numbers of teen mothers in the state, of 15,400, this means that between 7,700-9,240 have dropped out and become reliant on welfare for themselves and their children.

The Department of Public Health's MAPPS data regarding the educational status of pregnant and parenting teens indicates that of the 2,467 teens who participated at intake, 40.6% were out of school, with 27.1% out prior to pregnancy. At the birth of their child, of the 1,496 teens participating, 44.6% were out of school; at their child's age of 6 months, 47.2% were out. By the time their child was 18 months, of the 300 participating, 53% were out of school. Of the participants at intake, 1.9% graduated from high school, and of the 300 participants at the child's age of 18 months, 13.3% graduated from high school. A full breakdown of the educational status of those teens participating in the study is stated in table eighteen.

The MAPPS study data indicates that educational status by ethnicity breaks down as follows: 46.9% of white teens were out of school; 20.7% of black teens were out of school, and 57.7% of Hispanic teens were out of school. A further breakdown of educational status by ethnicity of teens participating in the study is stated in table nineteen.

A recent report on teens who drop out of school in Boston, entitled, "A Working Document on the Dropout Problem in the Boston Public Schools" states, "there are many factors contributing to teens dropping out - pregnancy, poverty, family problems, and social and behavioral problems." The report states that a study of

each senior class since 1981 shows that the percentage of dropouts has increased at least by 2% each year, from 36.2% in 1981 to 43% in 1985. Nearly 1500 girls or 41% of the total dropped out, and many of them were pregnant or already mothers. Rates were high for blacks and Hispanics, and for those receiving special education instruction. Many dropouts had already been suspended at least once. The report said that the Boston schools were losing many "marginal students". Bob Schwartz, head of the citywide task force on dropout prevention, stated, "perhaps the gap between the kids who are making it and the kids who aren't is growing here. The absence of support services may actually be helping the kids answer the question, 'what's in it for me, why should I stay?'"

Day Care for Parenting Students

The availability of child care is one of the most critical determinants of whether or not a teen parent is able to continue in school. School-age mothers have a continuum of needs that change from their pregnancy period through parenting. When young teens become pregnant, have their child, and attempt to return to school, these needs become even more extensive. Continuing in school is a difficult, often impossible task for most of them. One of the most critical needs, and one that remains a seriously unmet need in Massachusetts, is that of provision of day care and transportation to teen mothers to allow them to return to school, and remain there until completion.

Early childbearing is the major cause of young mothers dropping out of school. The consequences of dropping out, combined with a lack of work experience and the limitations imposed by child care and other responsibilities, severely hamper and impede the teen mother's efforts to participate in the labor market. Neither the teen mother nor father are likely to have the opportunities to learn and acquire the educational, vocational, or employable skills

necessary to enable them to work towards economic independence. According to a recent report from the Senate Office of Research in Washington, D.C., to Senator Gary Hart, entitled, "A Special Report on Adolescent Pregnancy", "adolescent parents are more likely to have heavy family responsibilities and are not as likely to acquire the work experience necessary to secure jobs in higher socioeconomic brackets. Further, if an adolescent does find a job, it is likely to be of lower socioeconomic status, resulting in lower hourly wages and annual earnings. The daily financial problems of adolescent parents are further intensified by their early parenting in that early childbearers, especially those who drop out of school, are likely to have more children than older mothers." A report from the National Conference of State Legislatures on initiatives addressing teenage pregnancy and parenting, "the lack of adequate day care is the teen parent's single greatest barrier to participation in educational programs."[92] The Alliance for Young Families report states, "day care has been consistently identified by researchers, providers, and teen parents alike, as a critical service whose provision and utilization can have a positive impact on young parents. It contributes to their ability to return to complete high school, participate in job training programs and employment, and developing parenting skills. Indirectly, it can contribute to reducing subsequent pregnancies and births."

Enhancing the opportunities of young mothers through the provision of day care services has long-term beneficial effects on both the individual and social costs of early childbearing.

A report entitled "A Review of Three Statewide Comprehensive Educational Programs for School Age Mothers: California, Michigan, Delaware", states,"estimates suggest that approximately 30% of high school drop outs are due to pregnancy. Only a small percentage of school-age parents return to school after the delivery

(20-30%), and, of those, still fewer actually complete high school. Successful programs incorporate support for educational goals both during the pregnancy as well as after delivery."[93]

From both an interventive and preventive perspective, the availability of child care services to teen parents in need is an important step in supporting family development and in promoting the economic self-sufficiency of this population. Accessing school age mothers back into school, facilitated by day care and transportation, improves their life options, and experiences, and expands their resources and choices, rather than enforcing a life of social and financial dependence, loss of self-worth, and a lack of employable skills - all of which destines many young women to a life of personal, social, and economic dependence, an erosion of self-confidence, and continuation for them and their children in a generational cycle of poverty.

SOCIAL AND ECONOMIC CONSEQUENCES OF EARLY PREGNANCY AND PARENTING

There are various factors that determine a young woman's pathways to welfare dependancy and poverty. Births to teen mothers are more likely to mean a potential head of an AFDC household at some point in time for them and their children. Many teen mothers are likely to become part of the working poor and the near poor. Because many teenage women are becoming pregnant and having children long before they are prepared socially, emotionally, and economically, teen pregnancy and parenthood are associated with a full range of adverse social and economic consequences.

The Rockefeller Foundation report states, "teenage childbearing for many youngsters is a symptom of an even larger and more complex problem, namely deprivation, and that there is no way that the symptom will disappear without attention to the quality of life that is producing early maternity." The report also ident-

ifies some of the causes of deprivation: racism, urban decay, automation, family disorganization, welfare policies, illiteracy, housing patterns and other complex factors.[94]

A report from the Guttmacher Institute states, "it is costly to the society both in direct expenditures for health and social services, and in the loss of the economic contributions that teen parents might have made if their educational and vocational choices had not been circumscribed by early childbearing."

Family Structure

The problems relating to family structure also contribute to the generally low socioeconomic status of teen parents and of unmarried women who became parents while in their teen years.

Only 10% of teens marry while they are pregnant, or during their child's early years. Of those who do marry, the divorce rate is nearly 50%. There are strong indications of an increasing trend towards nonmarital births among teenagers.

According to the Children's Defense Fund, nearly one-half of married women who give birth prior to age 18 are separated and divorced within 15 years, which is a rate three times higher than that of women who first bear children later than age 20 years. Nearly one-fourth of the separations are within 5 years. By the time these women are divorced or separated, they are likely to have more children, yet are less likely to receive child support payments. Only one in ten mothers below age 25 years ever receive child support from the child's father compared with one in four in older mothers. Those teen mothers who do receive child support, generally get less than $1500 a year.[95]

The Center for Population Options in Washington states that 71% of AFDC recipients under age 30 years had their first child while they were teens. Currently, 60% of all poor families are headed by women. Nearly 82% of teenage

women who gave birth at age 16 years and younger were daughters of teenage mothers.[96]

Between 1950 and 1979, the number of children born out of wedlock in the United States quadrupled for both blacks and whites. In 1985, four out of five young women giving birth are unmarried.[97]

A report from the Children's Defense Fund entitled, "Preventing Children Having Children" states, "in 1983, the proportion of black women under age 20 years giving birth out of wedlock was 86%, guaranteeing poverty for black children in the future."

The report also states, "women who deliver babies outside of marriage face greater risks than married women in the areas of poverty, the health of their babies, including low birthweight and infant mortality, and other such social and economic problems."

The number of teen mothers in Massachusetts decreased between 1970 and 1980. During this period, the number of unmarried school-age mothers (17 years and under) increased more than 35%, and unmarried 18 and 19 year olds increased by 48%.

According to the Department of Public Welfare, "one of the most dramatic shifts in the composition of the AFDC caseload is the increase in the proportion of AFDC parents who have never been married. In 1975, only a minority of AFDC single-parent families had never married(23%). By 1985, half of all AFDC single-parent families had never married. AFDC dependency is more and more the product of births to unmarried women and the lack of family formation, rather than the result of marital dissolution."[98]

In 1982, births to unmarried young women under age 20 years totaled 62.3% of all births to teenagers, ranking Massachusetts the 6th highest in the country

of births to unmarried teenagers. In 1984, 4,746, or 67.6% of all teen births were to unmarried teens. Of the total number of teen births in 1984 of 7,016, 5,766, or 82% were to white teenagers. Of these, 2,127, or 30.3% were married and 3,639, or 51.8% were unmarried. Of the total of all teen births in that same year, 1,043, or 14.8% were to teens who were of other ethnic/race origins. Of these, 90, or 1.2% were married, and 953, or 13.5% were unmarried. A breakdown of those teens who gave birth in 1984 and who were unmarried is stated as follows by age:

under 15 years	81
15	244
16	620
17	1032
18	1376
19	1393

The Department of Public Health's MAPPS study reported the living arrangement of participating teenagers by ethnicity. The results are stated in table twenty. The living arrangements of the infants of these teens is stated in table twenty-one.

Children in Poverty

Over 12 million children, or one in five, live in female headed households in the United States. According to the Census Bureau, one-half of all children born today will spend at least one year living with only one parent. Nine out of ten will live with their mother. The proportion of children living in female headed households more than doubled for both blacks and whites from 1960 to the present. For black children, one-half live in female headed households, as compared to one in seven white children. Children living in female headed households are 4 times more likely to be poor than children in two-parent families.[99]

In 1983, 55% of children in female headed households were poor; 47% of all white and 69% of all black children were poor.[100] One out of every 5 children under age 5 years lives below 150% of the poverty line.

The report from the Children's Defense Fund states, "being born into a white family headed by a never married female increases the expected number of years of child poverty by nearly 700%. Black children are at increased risk of long term poverty regardless of household status."

In Massachusetts, as nationally, one out of every 5 children is poor. In Boston, one out of every three children is poor. According to the Department of Public Welfare, "One of the most unfortunate consequences of the growing proportion of births to unwed parents is the number of Massachusetts children in poverty. Over 19% of all children born in Massachusetts during 1984 had spent some time on the welfare caseload by November 1985, and 17% had received AFDC. In 1984, 14% of all children under 19 were poor."

The Department's FY'87 Budget Narrative states, "when a single-parent family is headed by a young parent, the incidence of poverty is particularly severe. 29% of all children born in 1984 to a mother under age 19, or 2,035 children, and 28% of children born to a mother between 20 and 24 had been on the AFDC caseload by November, 1985. Moreover, there is a relationship between teen pregnancy and persistent welfare dependency."A list of cities and towns in Massachusetts of children less than 5 years of age living below 100% and below 200% of poverty is given in table twenty-two.

Employment Potential

Teenagers who have children when they are 18 years or younger earn about two-thirds as much as those who wait until they are 20 or older. Teenage mothers who drop out of school earn about one-half during their lifetime, if they earn

at all, of the income of those who remain in school, and delay parenthood.

Nationally, the teen unemployment rate for black teens is twice or more times that for white teens. In June, 1954, 42% of white 16-19 year olds and 38% of black 16-19 year olds were employed. In June, 1984, 56% of white youths were employed, but only 27% or one out of four black youths held a job.

Teen Families in Poverty

Nationally, of all AFDC families, 93% have lost the support of one or more parents due to continued absence of the parent from the home. In 1983, 46.9% of white female heads of household were poor; in the same year, 68.5% of black female heads of household were poor. Only one black single mother in four will escape poverty; one in two white single mothers will escape. If the present trends continue, two-thirds of school-age mothers who are 20-29 years by 1990 will receive AFDC during the coming decade.[101] Nearly 75% of single mothers under the age of 24 years live below the poverty level; most of these are, or were, teenage mothers. Of all families with children ages 5 years or younger, headed by mothers who have given birth as teens, 67% are living below the officially designated poverty level. Among mothers under age 30 years who have not finished high school, as most teenage mothers do not, the poverty rate is 90%.[102]

Teenage pregnancy is related to the length of time families remain on AFDC. An article entitled, "Innovative Strategies for State Social Services"[103] states, "most women who go on welfare receive assistance for relatively short periods; more than half stay for less than two years. However, research...suggests that the teen-age mother is likely to be a long-term welfare recipient...A high school dropout who had a child as a single parent averages ten years of welfare receipt."

Research has shown that a majority of families enter into the AFDC caseload because of a family crisis, such as divorce, separation, or birth to an unwed woman.[104] On the average, 45% enter because a mother became divorced, separated, or widowed; 30% enter because an unwed woman gave birth to a child; 16% enter because the family's income declined; 9% enter for other reasons.

In 1983, according to the Division of Employment Security, the total poor in Massachusetts were 473,900. Of these, female heads of household and their children represented 47.3% of all those people living in poverty.

Currently, in Massachusetts, there are 85,000 families receiving AFDC. According to the Department of Public Welfare,[105] these represented 80% of all poor families in Massachusetts in 1984. An estimated 1 in 14 Mass. families received AFDC in 1984. Nearly 86% of AFDC families are headed by a single female parent. This translates to 71,400 families on AFDC that have single female parents as household heads. Over half of these families have a child under age 6 years.

In 1985, 12.5% of entrants into the AFDC caseload were under 19 years of age, which is above the 1984 level of 11.4%. The Department of Public Welfare states, "a substantial portion of welfare dependency is related to teenage pregnancy". Entrants into the AFDC caseloads are younger, and have smaller families than those entering in previous years. This factor makes it more difficult to involve the teen parents in job training and job placement programs.

Of all AFDC single female parents under age 35 years, about 50% gave birth to their first child while under age 19 years. This means that 27,200 single parents on AFDC were 19 years or under when they had their first child.

While the Department of Public Welfare can identify all teen clients and those teen clients who have their own AFDC cases, it cannot identify those teens who are pregnant or are parents and are living at home on their mother's AFDC grants.

In March, 1985, 5,907 teenage parents were on welfare with their own AFDC caseloads. This includes cases in which the teenager and her dependent are eligible for AFDC and those cases in which only the dependent child is eligible. Of those teens who are 18 years and under who have their own AFDC cases, there are 2,305 cases in which the teen and her dependent are eligible. An additional 917 teens in this age group have cases in which their dependents are eligible for AFDC, but they are not, primarily because the income of the teen parents is too high for the teen to qualify for AFDC. Of the 19 year old AFDC teen parents, there are 2,344 cases in which the teen and her dependent(s) are eligible, and 341 cases in which only the dependent is eligible for AFDC. There are 153 teen parents who are 15 years old and under who are heads of AFDC households.[106]

In 1985, there were 802 AFDC cases of teens who were pregnant, with no other dependents. These figures do not include those pregnant and parenting teens who live with their own parents and are therefore on their mothers' AFDC grants. Outreach to teens who live with their parents is difficult because they often do not have contact with the local welfare offices and social service agencies.

The following table gives the numbers of teen parents with their own AFDC cases, by age, for 1985:[107]

Age	Total Number of cases	Teenager and dependent eligible	Child only eligible	Pregnant Teenagers
19	2685	2344	341	319
18	1908	1527	381	325
17	876	534	342	94
16	285	158	127	38
15	83	35	48	14
14 & under	70	51	19	12
	5907	4649	1258	802

In order to provide access to health services to pregnant minors, Medicaid pays for eligible teens according to Medicaid income standards. Teens are stated to be eligible if the parents cannot afford the services, do not know about the pregnancy, or refuse to assist the teenager. Medicaid services are not limited to Ob-Gyn services alone. In addition to Medicaid services provided to teens who are on AFDC caseloads, the Department of Public Welfare provided full medical coverage for about 130 pregnant teenagers who lived at home, but whose parents were unable or unwilling to pay for their medical care, in 1985. These families were of low income and financially ineligible for Medicaid.[108]

The Department of Public Welfare reports that of the current 19 permanent shelters, 15 of them, plus 2 new shelters, **are targeted** specifically for families or combinations of families, and individuals. The total capacity is 69 families, and they are continuously filled. Preference is given to single and very young mothers and their children. Some shelters do not accept single pregnant young women without children. Teen parents and pregnant women are given priority access to the Department's contracted emergency shelters. Among the approximately 90 persons housed in family shelters in September, 1985, just under one-half were adolescent mothers. Over half of the women in the shelters were pregnant, with pregnant teens slightly outnumbering women over 20 years. Families typically stay in shelters between 4 and 6 months.[109]

Among the 548 families housed in hotels and motels in August, 1985, 72 were adolescent parents and 16 were pregnant adolescents. The average stay for adolescent parents is 3 months, and for pregnant adolescents, 3-1/4 months.

SOCIAL AND ECONOMIC COSTS

According to the Urban Institute, in the United States in 1975, $8.5 billion was spent on federal AFDC, food stamps, and Medicaid programs for pregnant and

parenting teens and their children. A decade later, in 1985, this figure had nearly doubled, approaching $16.6 billion, according to the Center for Population Options in Washington, D.C. These figures do not include housing, costly health and medical consequences, education and possibly special education for both mother and child, social services, mental health services, and other such factors.

A 1982 study from the Center stated that projections of public sector costs associated with adolescent parenting, with continuation of present trends, are that women 20-29 years old will cumulatively receive $47.5 billion in AFDC, Medicaid, and food stamps between 1981 and 1990. Of that amount, $39.6 billion will go to women whose first births occurred when they were under 20 years old. Nationally, the 387,000 first born infants to teen mothers in 1985 alone could cost more than $6 billion over the next 20 years.

In 1985, in Massachusetts, the number of teenagers, ages 13-19 years, who had their own AFDC cases for themselves and their dependent(s), totaled 4,649. Assuming that they each have only one child, which many do not, the yearly public costs of these receiving AFDC, food stamps, and the Medicaid average per family, totals about $39,500,000. An additional 1,258 teenagers receive welfare for their dependents only, but not themselves. When these figures are added in, the total approaches $43,800,000. When figures are added in for the additional AFDC cases of pregnant teenagers, the total reaches $46,500,000 million. Again, these figures do not include those pregnant and parenting teens who live with their parents and are therefore on their mothers' AFDC grants. When public costs of social services and public health, and other such programs that service pregnant and parenting teenagers are added, the figures soar to nearly $55,000,000 million. These figures do not include sometimes needed foster care placements or group

care or residential placements for both mother and child, special education for both mother, and often long-term for children, shelters, services for runaway pregnant and parenting teens and their children, substance use and abuse often experienced by pregnant and parenting teens, and other costs related to adolescents and the problems they are experiencing today.

In terms of human and financial costs and expenditures, the short and long term impact and consequences of early pregnancy and childbirth are immeasurable.

HEALTH COSTS

According to national data, Medicaid pays for the hospital delivery of one out of every three teenage mothers.

According to the Boston Committee on Access to Health Care, "...of the 4,600 annual low birthweight babies in Massachusetts (627 such births to teens in 1984), some 340 are disabled to the point of requiring specialized and long-term care services. Massachusetts costs per year for these babies probably amount to between $9 million and $26 million, depending on whether the child is in a nursing home at $26,000 a year or in a state school at $75,000 a year. By the age of 21 these children will have required services costing between $189 million and $546 million. Like neonatal intensive care costs for the near-poor, these costs are generally incurred by the Commonwealth.

The average cost of caring for a low birthweight baby in a hospital intensive care unit is between $10,000 and $15,000. There are other costs associated with health complications that are experienced by teen mothers and their children that should be considered in cost analysis regarding health care.

Cumulatively, millions could be saved in public costs with sound investment in the present in terms of comprehensive, multiservice programs and services that would emphasize prevention and intervention, as opposed to long-term reliance on

welfare, becoming entrenched in the consequences of poverty, health risks and complications in all areas of adolescent health, and the health of their children and infants. Reports consistently state that for each $1.00 invested in prevention of health complications and medical problems, $4.00-$6.00 are saved in consequential costs.[110]

IMPLICATIONS FOR PREVENTION STRATEGIES, PROGRAMMING, AND SERVICES

Nationally, there are many programs that have delivered comprehensive services and programs to pregnant and parenting teens for several years. Many more have recently been established, and more are in the planning stages. One of the first steps many of these programs have taken is to bring services and programs to where the youth are - in the schools, communities, teen clinics - and to bring to the youth, and involve them in, services and programming that is relevant and feasible and appropriate to their needs, and the needs of the particular environment in which they live. Another barrier removed is that which prevents many parenting teens from returning to school, or staying in school to complete their education. Two such barriers are day care and transportation. A large number of these programs have established day care facilities for student parents on school property, where they also provide an environment in which teens who are pregnant, parenting, or not, can learn parenting skills and child development. These programs have been found to be highly effective.

Efforts must be made to retain, and return many of these teen parents in school, as a strong preventive strategy. Interventive and preventive strategies must be mobilized long before students reach the level of alienation and disaffection that leads to their dropping out of school. School retention and dropout prevention help ensure for many youth, a broadening of their opportunities, and an improvement of their life options and experiences. Incentives need to be

provided to pregnant and parenting students and other high-risk youth. Programs must be available to promote self-esteem, higher aspirations and the skills to meet these aspirations, and greater achievements, while at the same time allowing the youth to become less dependent and reliant upon social and welfare programs. Teenage mothers and fathers need to sense a message of hope, that with help and support, they can overcome their difficulties and achieve the self-sufficiency necessary to become participating and productive members of society.

Program strategies nationally are organized around interventions in school involvement, coalitions, media, family involvement, church, social organizations, and community resource-building. Community networks and collaboratives, health services and human services cooperatives, both in schools and in neighborhoods, are in place, or being planned. Studies have found that no one isolated program or service delivery system is effective in preventing teen pregnancy and early childbearing, along with other adolescent problems. Many parts of the country have extensive comprehensive, multiservice, interdisciplinary programs and servicing networks and collaboratives that are community and inter-community based, and involve state and local agencies, public and private agencies, institutions and facilities, advocates, service providers, and funding sources. Research indicates that "free-standing" services are only moderately effective, and even ineffective, if not coupled with other programs that provide a full range of services. Comprehensive programs that are in place are better able to act and react to changing adolescent needs, rather than reacting to problems that have reached a crisis level.

Nationally, many states have comprehensive statewide programs, task forces, coalitions, servicing networks, councils, and collaboratives that are adaptable to community needs. Most provide services that meet the wide, complex needs and problems of adolescents, and involve the adolescents to a high degree of partici-

pation. These programs are proving themselves to be highly effective in intervening with high risk teenagers, early prevention and intervention with "marginal" teenagers, in providing self-worth and self-sufficiency skills, helping youth and children work towards feasible and realistic life options and assessments of those options, in retrieving and retaining dropouts, accessing teens to health care and counseling, job skills training, expanding life options, choices and opportunities, in providing family life education, sex education and services, in understanding human growth and development, and in providing educational and learning skills. These programs provide effective prevention strategies that involve teenagers, maintain them through follow-up periods, and help teens resolve their problems. Most begin in elementary grades and proceed on a continuum of sequential programming that is appropriate at each level and stage.

Despite concerns that programming which involves services around teenagers sexual behavior and pregnancy prevention, even when these services are placed in the context of the wide spectrum of problems being experienced by teenagers, promotes sexual activity and even pregnancy itself, the reverse has proven to be true. Studies have repeatedly documented that such programming promotes an adoption of positive health behaviors and attitudes, maturity in responsible decision-making and communication, postponing sexual involvement, an enhancing of self-worth and self-reliance, and a reduction in the rates of all behaviors associated with adolescent problems and conflicts. Such programs also help teenagers, through peer group sessions and parent-teen discussions, to resolve the confusing, often conflicting messages they receive about sexuality from the media, their peers and parents, and from the larger society.

Evaluations of such programs through institutions such as the Social Research Institute of Johns Hopkins University and other independent researchers, have

confirmed the previous statements. Other such studies have also confirmed the effectiveness of comprehensive, multiservice programming.

While Massachusetts has effective, specialized programming to meet adolescent needs and problems, there remains a lack of uniformity, consistency and follow-up, and a full range of programs and service networks that confront and address adolescent issues. An analysis and assessment of programs and services in Massachusetts, along with recommendations, will be presented in Part 2 of the Task Force Report.

TABLE 1

SEXUALLY TRANSMITTED DISEASE CASES IN MASSACHUSETTS ADOLESCENTS

Year	1980	1983	1984	1985
Ages				
Gonorrhea				
0-14	68		102	
15-19	1,988		1,844	
All Ages	10,795		9,799	
Syphillis				
0-14	0		0	
15-19	13		30	
All Ages	318		294	
Herpes				
All Ages	873	1,118		

TABLE 2

Source: DPH: Division of Health Statistics and Research

RESIDENT BIRTHS TO TEENAGE MOTHERS

1970-1984

YEAR	TOTAL BIRTHS	- AGE OF MOTHER - 12	13	14	15	16	17	18	19	TOTAL 12-19	PERCENT OF TOTAL BIRTHS
1970	93,582	3	8	70	320	802	1,726	3,043	4,285	10,257	11.0
1971	86,755	3	23	84	313	875	1,738	2,981	4,000	10,017	11.5
1972	76,835	1	20	103	348	955	1,841	2,834	3,690	9,792	12.7
1973	72,237	0	12	93	393	959	1,759	2,584	3,282	9,082	12.6
1974	70,071	2	16	79	333	895	1,762	2,524	3,181	8,792	12.5
1975	68,070	2	18	84	325	915	1,678	2,560	3,085	8,667	12.7
1976	65,947	7	12	96	336	807	1,478	2,332	2,923	7,991	12.1
1977	67,838	1	18	68	270	792	1,477	2,293	2,913	7,832	11.5
1978	68,526	3	15	67	303	737	1,445	2,252	2,979	7,801	11.4
1979	70,568	2	9	70	283	773	1,413	2,306	2,916	7,772	11.0
1980	72,591	1	14	56	300	740	1,360	2,202	3,092	7,765	10.7
1981	73,931	1	12	82	275	722	1,357	2,164	2,816	7,429	10.0
1982	75,749	1	14	83	299	753	1,328	2,161	2,722	7,361	9.7
1983	76,031	0	8	78	255	726	1,278	2,053	2,521	6,919	9.1
1984	78,198	9 (combined)		75	265	714	1307	2061	2585	7,016	9.0

There was an increase from 1983-1984 in total teen births, ages 12-19 yrs., of 97 births. Increases are in both age groups, 12-17 yrs. and 18,19 yrs. School age births, ages 12-17 yrs. increased by 25 births; older teens, ages 18,19 births increased by 72 births. Age breakdown is as follows: 12,13 yr. old births increased by 1 birth; 14 yr. old births decreased by 3 births; 15 yr. old births increased by 10 births; 16 yr. old births decreased by 12 births; 17 yr. old births increased by 29 births; 18 yr. old births increased by 8 births; 19 yr. old births increased by 64 births.

TABLE 3

DPH- Division of Health Statistics and Research

TABLE G-5
PROVISIONAL POPULATION ESTIMATES, MASSACHUSETTS*
1981-1984

AGE GROUP		TOTAL	MALE	FEMALE
0-4	1981	342,949	175,771	167,178
	1982	350,822	179,964	170,858
	1983	359,061	184,082	174,979
	1984	366,806	187,915	178,891
5-9	1981	352,084	180,047	172,037
	1982	336,800	172,328	164,472
	1983	328,230	168,158	160,072
	1984	328,034	167,900	160,134
10-14	1981	451,532	230,860	220,672
	1982	434,483	222,329	212,154
	1983	416,835	213,269	203,566
	1984	395,788	202,667	193,121
15-19	1981	528,400	267,178	261,222
	1982	508,802	259,216	249,586
	1983	495,716	250,450	245,266
	1984	478,534	241,959	236,575
20-24	1981	566,409	275,519	290,890
	1982	568,319	276,201	292,118
	1983	568,104	275,247	292,857
	1984	561,660	273,595	288,065
25-29	1981	499,488	244,660	254,829
	1982	510,779	250,409	260,370
	1983	520,689	255,208	265,481
	1984	533,889	261,050	272,839
30-34	1981	469,113	229,183	239,930
	1982	463,867	227,232	236,635
	1983	466,591	230,316	236,275
	1984	474,715	234,835	239,880
35-39	1981	358,747	174,409	184,338
	1982	386,535	187,989	198,546
	1983	402,070	195,315	206,755
	1984	419,181	203,551	215,630
40-44	1981	285,147	138,093	147,054
	1982	292,732	141,524	151,208
	1983	312,220	150,594	161,626
	1984	329,106	159,084	170,022
45-49	1981	272,195	131,695	140,500
	1982	268,502	129,579	138,923
	1983	266,074	128,538	137,536
	1984	269,193	129,857	139,336
50-54	1981	301,536	143,875	157,661
	1982	291,600	139,062	152,538
	1983	283,151	135,235	147,916
	1984	275,438	131,598	143,840
55-59	1981	309,026	144,679	164,347
	1982	305,617	143,416	162,201
	1983	303,017	142,449	160,568
	1984	298,378	140,678	157,700

TABLE 4

RANKING OF 25 MASS. CITIES AND TOWNS FROM HIGHEST TO LOWEST NUMBERS OF BIRTHS TO ADOLESCENTS, AGES 12-19 YRS., AND SCHOOL AGES 12-17 YRS.

	12-19 yrs.	1984	12-17 yrs.	%total births
Boston	1132		438	13.2
Springfield	504		198	19.2
Worcester	312		101	12.9
Lowell	248		92	14.4
Lawrence	246		101	18.8
Fall River	234		75	16.9
New Bedford	232		79	15.7
Brockton	226		72	13.9
Lynn	156		69	11.8
Holyoke	141		63	18.8
Taunton	94		38	13
Haverhill	93		31	12.3
Fitchburg	80		20	13.5
Pittsfield	78		25	11.4
Somerville	78		19	7.8
Chicopee	72		32	9.4
Attleboro	63		19	11
Cambridge	60		24	5.5
Chelsea	58		38	12.1
Leominster	58		17	11.3
Quincy	54		14	5.4
Westfield	51		15	9.9
Salem	49		20	9.3
Weymouth	48		19	7
Southbridge	44		16	17.6
North Adams	39		6	15.9
Wareham	39		9	15.9
Falmouth	37		12	11.8
Marlborough	37		9	8.2

Total of all adolescent births, ages 12-19 yrs. = 7016
ages 12-17 yrs. = 2370

* % total births means the % of teen births to total births for that city or town

RANK BY HSA, HIGHEST TO LOWEST ACCORDING TO NUMBER OF ADOLESCENT BIRTHS, CITIES AND TOWNS ARE RANKED WITHIN EACH HSA, HIGHEST TO LOWEST, RATINGS INCLUDE TOP 6 IN EACH AREA.

1984

			Total, 12-19 yrs.	School Age, 12-17 yrs.
Highest:	HSA 4		1,965	
		Boston	1132	438
		Somerville	78	19
		Cambridge	60	24
		Chelsea	58	38
		Quincy	54	14
		Weymouth	48	19
	HSA 5		1,484	
		Fall River	234	75
		New Bedford	232	79
		Brockton	226	72
		Taunton	94	38
		Attleboro	63	19
		Wareham	39	9
	HSA 1		1,249	
		Springfield	504	198
		Holyoke	141	63
		Pittsfield	78	25
		Chicopee	72	32
		Westfield	51	15
		North Adams	39	6
	HSA 2		1,009	
		Worcester	312	101
		Fitchburg	80	20
		Leominster	58	17
		Southbridge	44	16
		Northbridge	29	7
		Ayer	28	6
		(Clinton, Milford, Spencer, each 27)		
	HSA 3		818	
		Lowell	248	92
		Lawrence	246	101
		Haverhill	93	31
		Methuen	34	14
		Billerica	33	10
		Amesbury	27	3
Lowest;	HSA 6		491	
		Lynn	156	69
		Salem	49	20
		Beverly	33	7
		Medford	32	10
		Peabody	31	9
		Gloucester	29	6

OTAL TEEN BIRTHS, AGES 13-19 years:
1984-7,016
1983-6,919

-- over --

The top twelve cities and towns in Massachusetts in 1984 in the percent of teen births to total births for that city or town are:

Winchendon	22.7%
Springfield	19.2%
Lawrence	18.8%
Holyoke	18.8%
Southbridge	17.6%
Fall River	16.9%
Spencer	16.1%
North Adams	15.9%
Wareham	15.9%
New Bedford	15.7%
Northbridge	14.8%

Table 6

RESIDENT BIRTHS BY AGE, RACE AND MARITAL STATUS OF MOTHER
1984

AGE	- TOTAL -			- WHITE -			- NON-WHITE -			- UNKNOWN -		
OF MOTHER	TOTAL	WED	UNWED	TOTAL	WED	UNWED	TOTAL	WED	UNWED	TOTAL	WED	UNWED
TOTAL*	78,198	64,249	13,949	69,138	58,800	10,338	6,512	3,506	3,006	2,548	1,943	605
UNDER 15	84	3	81	57	3	54	23	0	23	4	0	4
15	265	21	244	195	19	176	54	1	53	16	1	15
16	714	94	620	547	89	458	145	5	140	22	0	22
17	1,307	275	1,032	1,050	257	793	217	10	207	40	8	32
18	2,061	685	1,376	1,711	653	1,058	294	20	274	56	12	44
19	2,585	1,192	1,393	2,206	1,106	1,100	310	54	256	69	32	37
20-24	19,516	14,448	5,068	17,184	13,340	3,844	1,797	769	1,028	535	339	196
25-29	26,862	24,301	2,561	24,115	22,346	1,769	1,864	1,237	627	883	718	165
30-34	18,273	17,178	1,095	16,345	15,593	752	1,279	1,002	277	649	583	66
35-39	5,785	5,381	404	5,105	4,822	283	442	342	100	238	217	21
40-44	722	652	70	609	561	48	80	60	20	33	31	2
OVER 44	22	17	5	13	10	3	7	6	1	2	1	1
UNKNOWN	2	2	0	1	1	0	0	0	0	1	1	0

*UNWED FIGURES INCLUDE 154 RECORDS WITH UNKNOWN MARITAL STATUS.

1983: Total abortions, 12-19yrs. = 8,881

School age, 12-17 yrs. abortions = 2,672

een abortions, ages 12-19 yrs. was 24% of all abortions; school age, 12-17yrs.=14.5% of all abortions

TABLE 7

RATE OF ABORTIONS TO BIRTHS BY AGE OF WOMAN

1983

AGE	# OF ABORTIONS 1983	% OF TOTAL ABORTIONS	1983 OCCURRENCE BIRTHS	% OF OCCURRENCE BIRTHS	RATIO OF ABORTIONS/BIRTHS
<15	194	0.5	86	0.1	2.1
15	473	1.3	260	0.3	1.8
16	832	2.2	724	0.9	1.1
17	1,173	3.2	1,276	1.6	0.9
18	2,749	7.4	2,066	2.7	1.3
19	3,460	9.3	2,575	3.3	1.3
20-24	14,058	37.7	20,056	25.8	0.7
25-29	7,896	21.2	27,309	35.2	0.3
30-34	4,114	11.0	17,497	22.5	0.2
35-39	1,815	4.9	5,219	6.7	0.3
40-44	454	1.2	645	0.8	0.7
45+	39	0.1	22	0.1	1.8
UNKNOWN	15	---	2	---	---
TOTAL	37,272	100.0	77,737	100.0	0.5

1982: Total abortions, 12-19 yrs. = 9,520
School age, abortions,
12-17 yrs. = 2,806

Source: DPH: Division of Health
Statistics and Research

Decrease of 639 from '82-'83 of ages 12-19 yrs.
Decrease of 134 from '82-'83 of ages 12-17 yrs.

TABLE 8

Source: DPH: Division of Health Statistics and Research

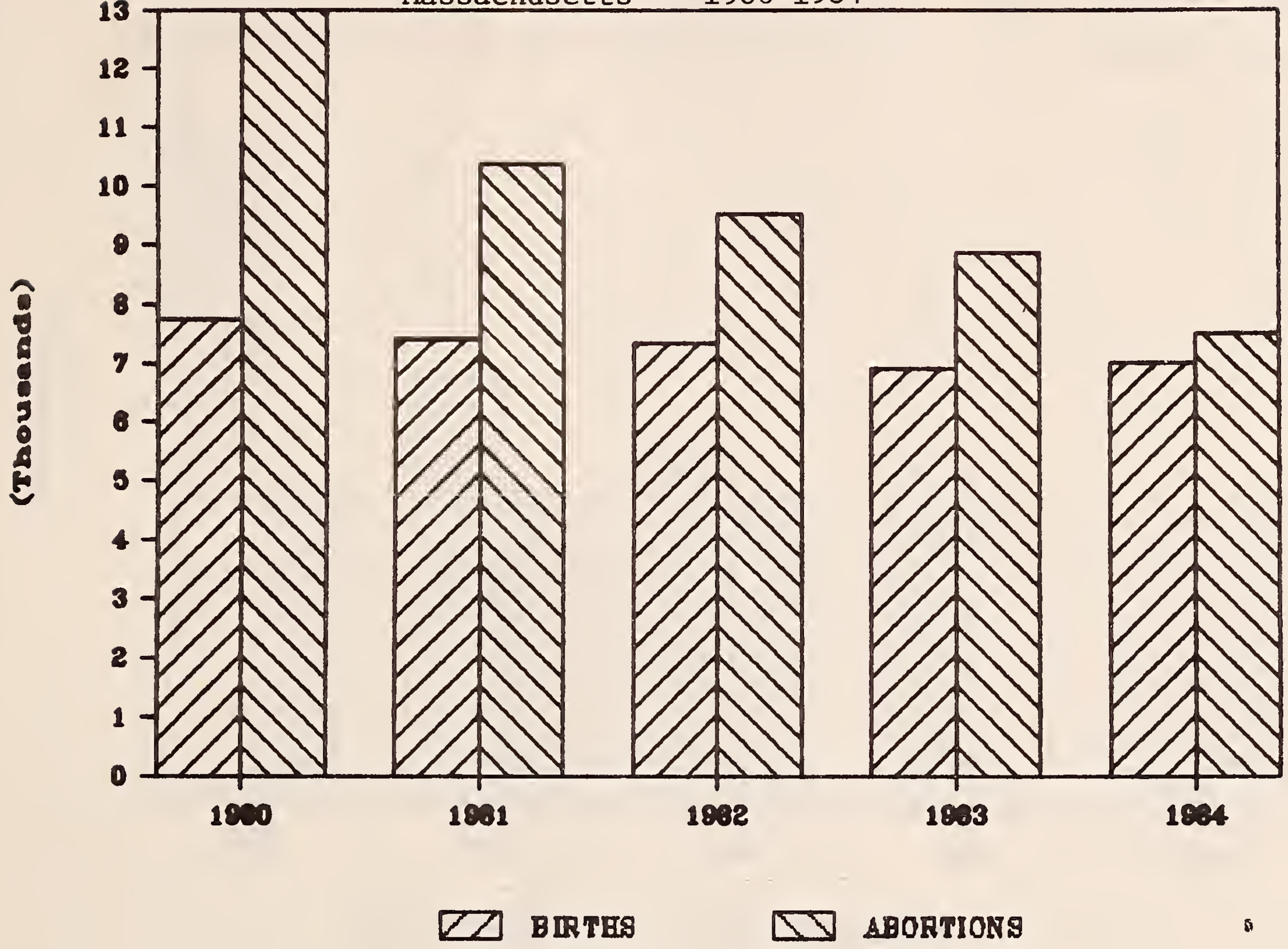
NUMBER OF ABORTIONS OCCURRING IN MASSACHUSETTS BY TYPE OF FACILITY AND AGE OF WOMAN
1984

AGE		TOTAL	CLINICS	PHYSICIANS AND GROUP PRACTICE	HOSPITALS
TOTAL	N	31,876	21,374	5,531	4,971
	%	100.0	67.0	17.4	15.6
<15	N	200	89	32	79
	%	100.0	44.5	16.0	39.5
15-19	N	7,322	4,020	2,195	1,107
	%	100.0	54.9	30.0	15.1
20-29	N	18,501	13,395	2,577	2,529
	%	100.0	72.4	13.9	13.7
30-39	N	5,395	3,612	650	1,133
	%	100.0	67.0	12.0	21.0
40+	N	441	258	73	110
	%	100.0	58.5	16.6	24.9
UNKNOWN	N	17	0	4	13
	%	100.0		23.5	76.5

Table 9

PREGNANT AND PARENTING TEENS

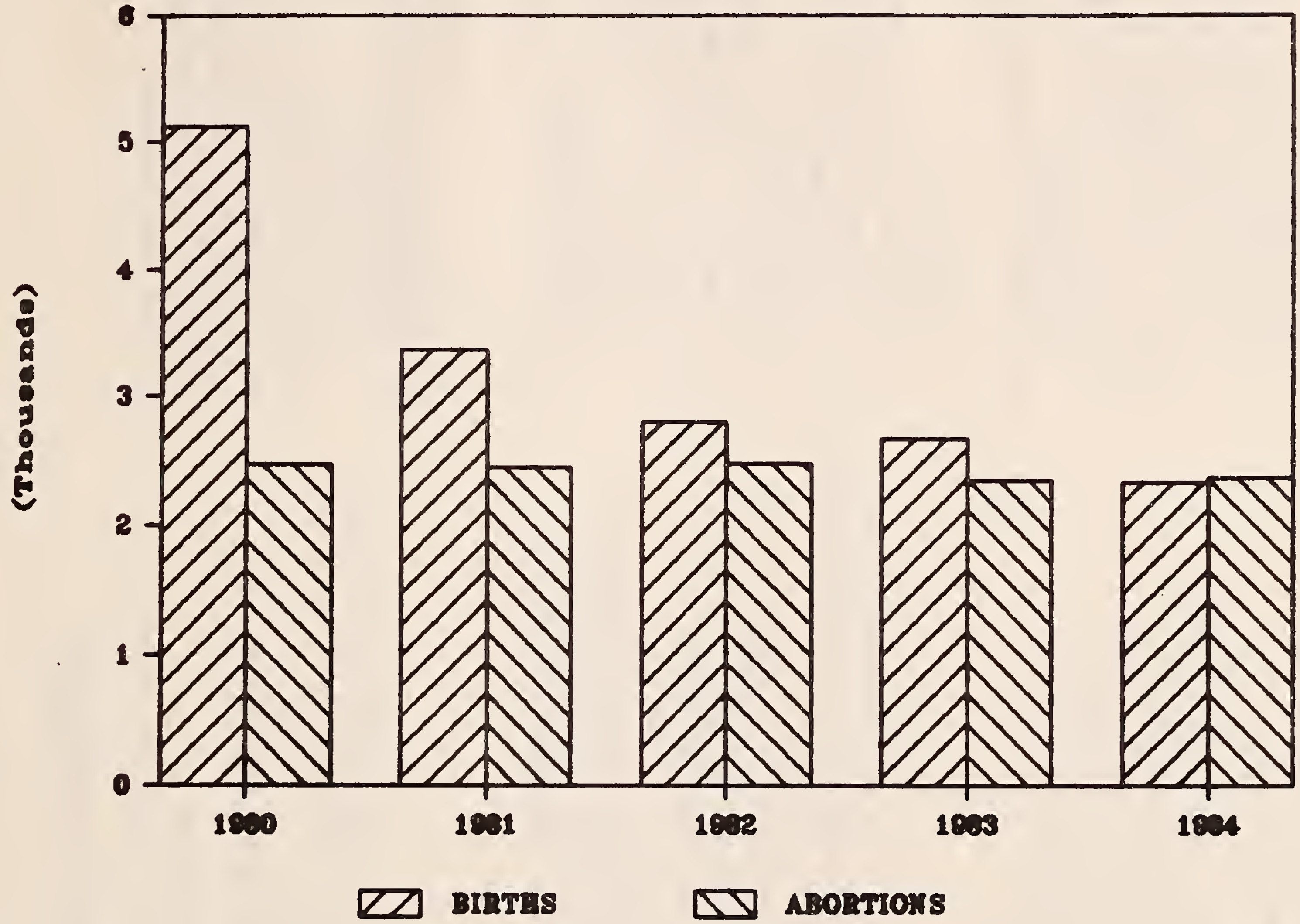
Massachusetts 1980-1984



	Births	Abortions
1980	7,765	13,000
1981	7,429	10,381
1982	7,361	9,520
1983	6,919	8,881
1984	7,016	7,522

Table 10

BIRTHS AND ABORTIONS 13 -17 YEAR OLDS



	Births	Abortions
1980	2,471	5,121
1981	2,449	3,365
1982	2,478	2,806
1983	2,345	2,672
1984	2,370	2,328

TABLE 11

ATTITUDES, MOTIVATIONS, AND BEHAVIORS THAT AFFECT THE PROBABILITY OF UNINTENDED PREGNANCY AND WELFARE DEPENDENCY

STAGE	ATTITUDES, MOTIVATIONS, AND BEHAVIORS	
1. ENGAGE IN SEXUAL ACTIVITY	a. No/low alternatives or future goals b. Ignorance of consequences c. Inability to plan d. Peer pressure, including attracting and keeping partner e. Ignorance of level of poor sexual activity f. Inability to discuss with signficant other g. lonliness	h. Low self-esteem i. Bad relationship with parents j. "Pro-love" cultural stimuli k. "Pro-sex cultural stimuli l. Fun, excitement m. Double standards, sex role stereotyping n. Confirmation of attractivness o. Support for sex-role identity
2. CONTRACEPTIVE USE	a. Ignorance of lack of cognitive maturity to understand: physiological processes, contraceptive techniques, consequences of pregnancy, probability of pregnancy b. Positive valuation of pregnancy or associated status: adult status c. Fear of parents finding out, losing partner, talking with partner d. Actual negative side effects of contraceptive use: feared side effects of contraception	e. Erratic sexual activity schedule: unexpected sex f. Availability of contraception: cost of contraception g. Denial of sexual activity: guilt h. Ideology (it's not natural; sex should be spontaneous) i. Risk-taking j. Thoughtlessness:lack of planfulne k. Inconvenience of contracepting l. Fear of embarrassment of physical examination
3. BIRTH AND RETENTION OF OUT-OF-WEDLOCK BABY	a. Denial of pregnancy b. Unacceptability of abortion to self, family, baby's father, community c. Unacceptability of adoption to self, family, baby's father, community d. Positive valuation of motherhood and having baby e. Good support system for child care f. Baby fullfills (at least temporarily need for attachment, being needed, purpose in life, lonliness abatement, rivalry with own mother or siblings	g. Greater acceptability of non-mari childbearing h. Welfare availability (for some) i. Bond with baby's father j. Poor performance in other roles (e.g. School failures) k. Acceptance of motherhood is punishment ("you made your bed, now lie in it") l. Adult status m. No/low understanding of difficult of parenting.

Source: Private Crisis, Public Cost, Moore and Burt, 1982, Ch. 10

4. MARRIAGE AND BIRTH	a. Social/moral pre re to marry b. Adult status of marriage c. Marriage secures relationship with baby's father: love d. Dependency (can't support self and baby without marriage)	e. Same motivation as in f. Already had marriage plans g. Father, unemployed, uses drugs, in jail, already married
5. WELFARE DEPENDENCY	a. Low job skills b. Incomplete education c. Susequent births d. Poor or nonexistent child care	e. Poor job training and remedial educa programs f. Poor job-search and self-presentatio skills g. Lack of jobs that provide wage and fringe benefits for self-support h. Traditional attitudes regarding mate employment

Table 12

1984
Births to Teenage Women
Selected Cities and Towns: Massachusetts

	% Adequate Care	% Teens Births of All Births	Number of Births	
			12-17 yrs	12-19 yrs
Massachusetts	54.4	9.0	2370	7016
Springfield	43.6 (6)	19.3 (1)	198	312
Lawrence	51.2	18.9 (2)	101	246
Holyoke	22.0 (1)	18.8 (3)	63	141
Fall River	53.0	17.0 (5)	75	234
New Bedford	53.0	15.8 (9)	79	232
Lowell	49.2 (11)	14.4 (11)	92	258
Chelsea	64.7	14.2 (12)	38	68
Brockton	47.3 (8)	13.9 (13)	72	226
Fitchburg	52.5	13.6 (14)	20	80
Boston	64.7	13.3 (15)	438	1132
Taunton	47.9 (9)	13.1 (16)	38	94
Worcester	64.4	13.0 (17)	198	504
Haverhill	60.2	12.4 (18)	31	93
Lynn	46.3 (7)	11.8 (20)	69	156
Pittsfield	64.1	11.5 (21)	25	78
*Southbridge	29.5 (2)	17.6 (4)	16	44
*Spencer	63.0	16.2 (6)	3	27
*North Adams	61.5	16.0 (7)	6	39
*Wareham	61.5	15.9 (8)	9	39
*Webster	48.1 (10)	14.6 (10)	7	27
Falmouth	35.1 (3)	11.9 (19)	12	37
Leominster	37.9 (5)	11.4 (22)	17	37
Attleboro	57.1	11.1 (23)	19	63
Chicopee	36.1 (4)	9.5 (24)	32	72
Marlborough	73.0	8.2 (25)	9	37
Somerville	60.3	7.8 (26)	19	78
Weymouth	62.5	7.1 (27)	19	48
Waltham	57.1	6.7 (28)	10	42
Malden	56.8	6.1 (29)	9	44
Peabody	48.7 (11)	5.7 (30)	9	31
Cambridge	66.1	5.7 (31)	24	62
Quincy	72.2	5.5 (32)	14	54
Medford	62.5	4.5 (33)	10	32

*These 5 towns have less than 50 teen births and are not among the 20 largest towns in the Commonwealth. However they rank in the top 10 for percentage of teen births to all births

MDPH - Vital Statistics 1984.

Table 13

FACTORS INFLUENCING ADEQUACY OF CARE:

CROSSTABULATION OF VARIABLES II

	ADEQUATE	INTERMEDIATE	INADEQUATE OR NONE
ETHNICITY*			
WHITE			
STATE n=3127	49.7	39.6	10.7
MAPPS n=889	48.7	35.6	15.7
BLACK			
STATE n=607	53.2	35.9	10.9
MAPPS n=537	32.4	45.2	22.4
HISPANIC			
STATE n=436	57.6	33.0	9.4
MAPPS n=270	45.2	40.7	14.1
OTHER			
MAPPS n=62	33.9	46.8	19.3

p=.0001 for MAPPS compairson.

TABLE 14

BIRTH OUTCOMES BY ADEQUACY OF CARE

	ADEQUATE	INTERMEDIATE	INADEQUATE OR NONE
LOW BIRTH WEIGHT*			
LT 2500 Grams n=194	8.0	11.2	18.1
GE 2500 Grams n=1564	92.0	88.8	81.9
MATERNAL COMPLICATIONS (a)			
None n=1295	77.1	72.5	68.1
One n=393	20.1	22.6	27.1
Two or More n=70	2.8	4.9	4.8
INFANT COMPLICATIONS (b)			
None n=1655	94.3	94.6	92.9
One or More n=103	5.7	5.4	7.1

*p=.0001

(a) Includes anemia, pre-eclampsia, eclampsia, hemorrhage, sepsis, premature labor, rupture of membranes, and other.

(b) Includes apnea, respiratory distress syndrome, neonatal pneumonia, sepsis, jaundice requiring transfusion, and other.

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TABLE 15

SUBSTANCE USE

TOBACCO

	INTAKE n=2465	BIRTH n=1478	6 MOS n=942	12 MOS n=554	18 MOS n=291
Never	52.6	56.6	51.9	48.8	42.3
Ever Used	47.4	43.4	48.1	51.2	57.7
Quit (a)	--	13.7			

ALCOHOL

	INTAKE	BIRTH	6 MOS	12 MOS	18 MOS
Never	73.1	72.8	59.8	57.9	53.3
Ever Used	26.9	27.2	40.8	42.1	46.7
Quit	--	21.5			

MARIJUANA

	INTAKE	BIRTH	6 MOS	12 MOS	18 MOS
Never	83.2	86.4	82.3	81.6	84.5
Ever Used	16.8	13.6	17.7	18.4	15.5
Quit	--	36.3			

OTHER ILLICIT SUBSTANCES

	INTAKE	BIRTH	6 MOS	12 MOS	18 MOS
Never	95.2	96.6	97.0	96.4	93.5
Ever Used	4.8	3.4	3.0	3.6	6.5
Quit	--	46.0			

(a) Quit rate percent is based on user rate.

TABLE 16

SUBSTANCE USE QUIT RATES BY ETHNICITY

(during pregnancy)

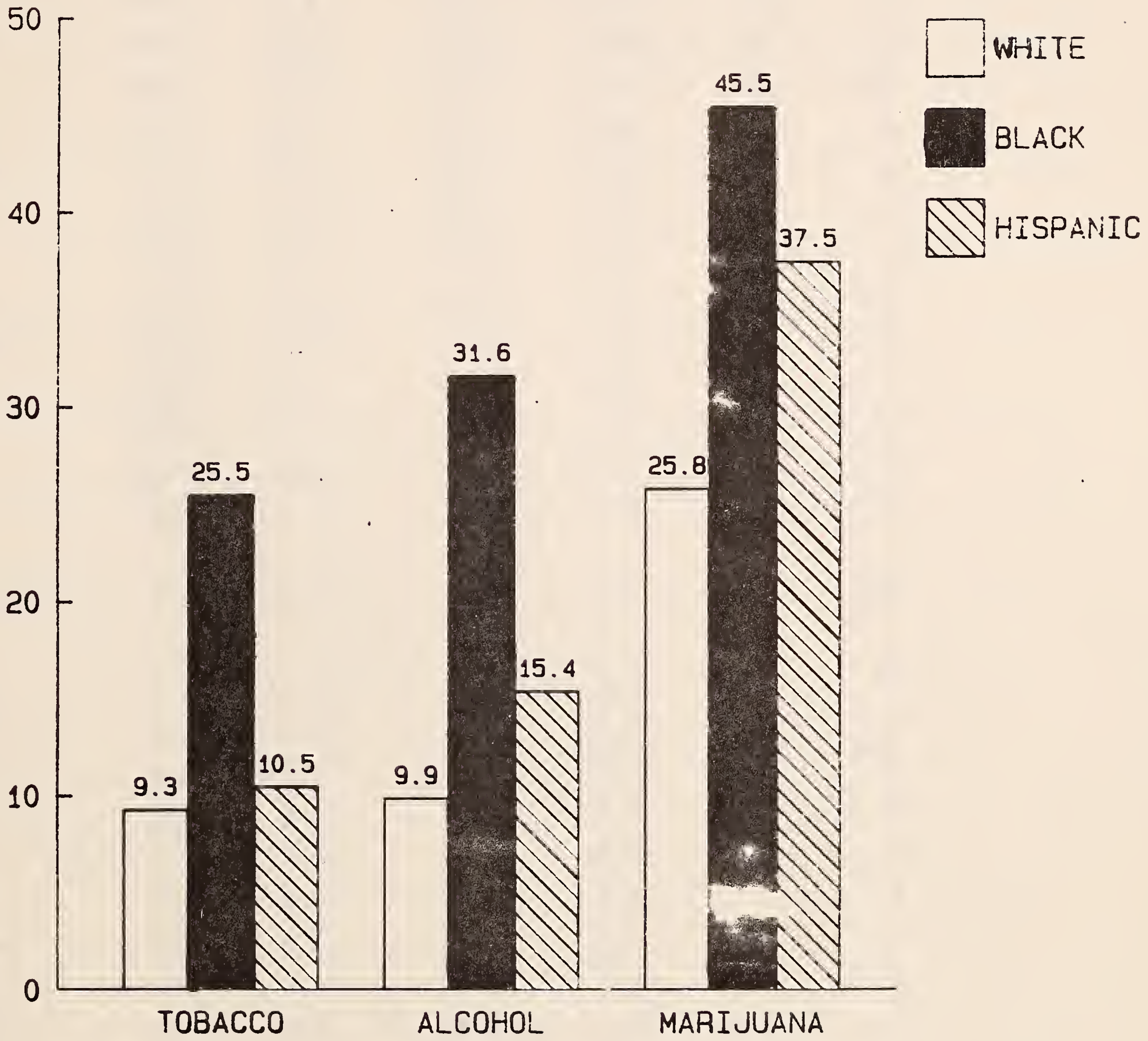

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Table 17

INFANT MORTALITY RATE
FOR 25 LARGEST CITIES IN MASSACHUSETTS
(Based on number of births)

City	5 Year IMR		1 Year IMR		Number of Infant Deaths	
	1979-83	1978-82	1983	1982	1983	1982
Springfield	15.7	15.8	12.1	15.0	30	37
Holyoke	15.7	14.8	13.8	10.5	10	8
Haverhill	14.0	12.6	21.9	17.5	16	13
Boston	13.6	14.5	11.5	15.8	96	132
Lawrence	11.8	12.1	6.8	16.8	9	21
Fitchburg	11.6	12.6	6.7	15.8	4	9
Brockton	11.6	11.3	10.3	8.2	17	13
Malden	11.5	11.5	11.0	10.5	8	7
Worcester	11.3	11.8	11.2	11.2	26	26
New Bedford	11.3	11.2	11.2	14.3	16	22
Chicopee	10.8	10.1	13.0	12.5	9	9
Lowell	10.7	11.9	10.8	9.2	17	15
Medford	10.4	12.0	4.4	23.2	3	15
Lynn	10.3	11.9	9.5	9.9	12	13
Massachusetts	9.9	10.3	9.0	10.1	682	764
Fall River	9.0	10.2	7.5	9.9	10	13
Somerville	8.9	9.0	9.4	3.0	9	3
Quincy	8.8	9.6	7.7	10.1	8	10
Waltham	8.8	8.1	10.9	7.8	7	5
Plymouth	8.7	7.0	10.8	8.5	6	5
Taunton	8.5	9.5	5.9	8.6		6
Framingham	8.2	8.6	6.7	5.9	5	4
Cambridge	7.8	9.4	2.8	7.9	9	8
Pittsfield	7.7	8.9	8.8	7.5	6	5
Weymouth	7.7	6.9	10.2	3.0	7	2
Newton	6.2	6.2	10.3	4.8	9	4

Data Source: Division of Health Statistics and Research, MDPH

Prepared By: Division of Family Health Services, MDPH

TABLE 18

EDUCATIONAL STATUS

	INTAKE n=2467	BIRTH n=1496	6 MONTHS n=937	12 MONTHS n=559	18 MONTHS n=300
In School	54.4	45.1(a)	30.0	22.9	16.7
In GED Program	2.4	1.7	6.5	6.6	6.0
Out of School	40.6(b)	44.6	47.2	48.3	53.0
Graduated H S	1.9	6.8	12.1	15.9	13.3
Received GED	0.6	1.3	2.9	4.3	6.3
Post-Ed	0.2	0.5	1.4	2.0	4.7
In or Completed Vocational Training	8.3	5.2	5.9	10.5	14.1

(a) 10.1 In alternative school.

(b) 27.1 Out prior to pregnancy.

TABLE 19

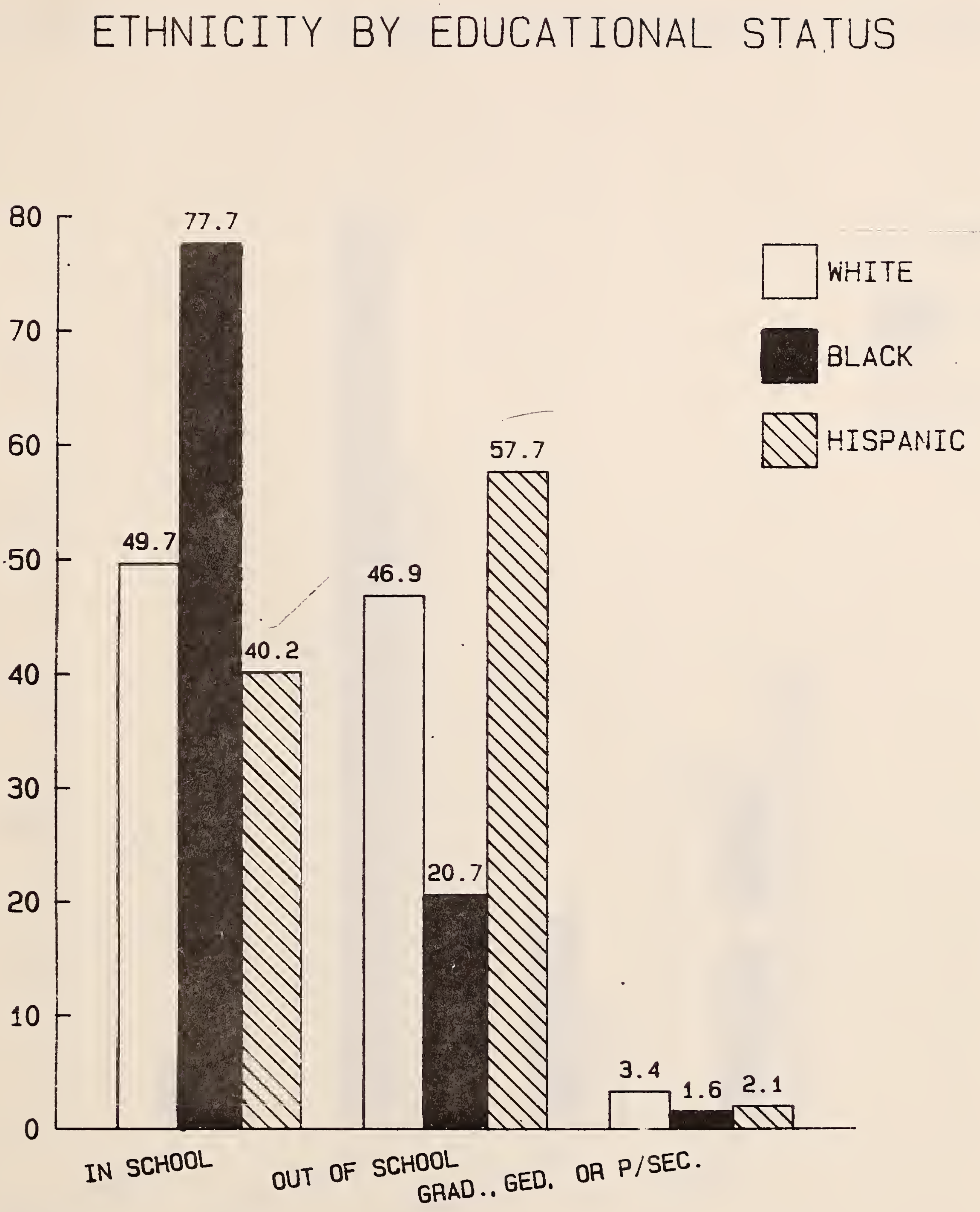

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TABLE 20

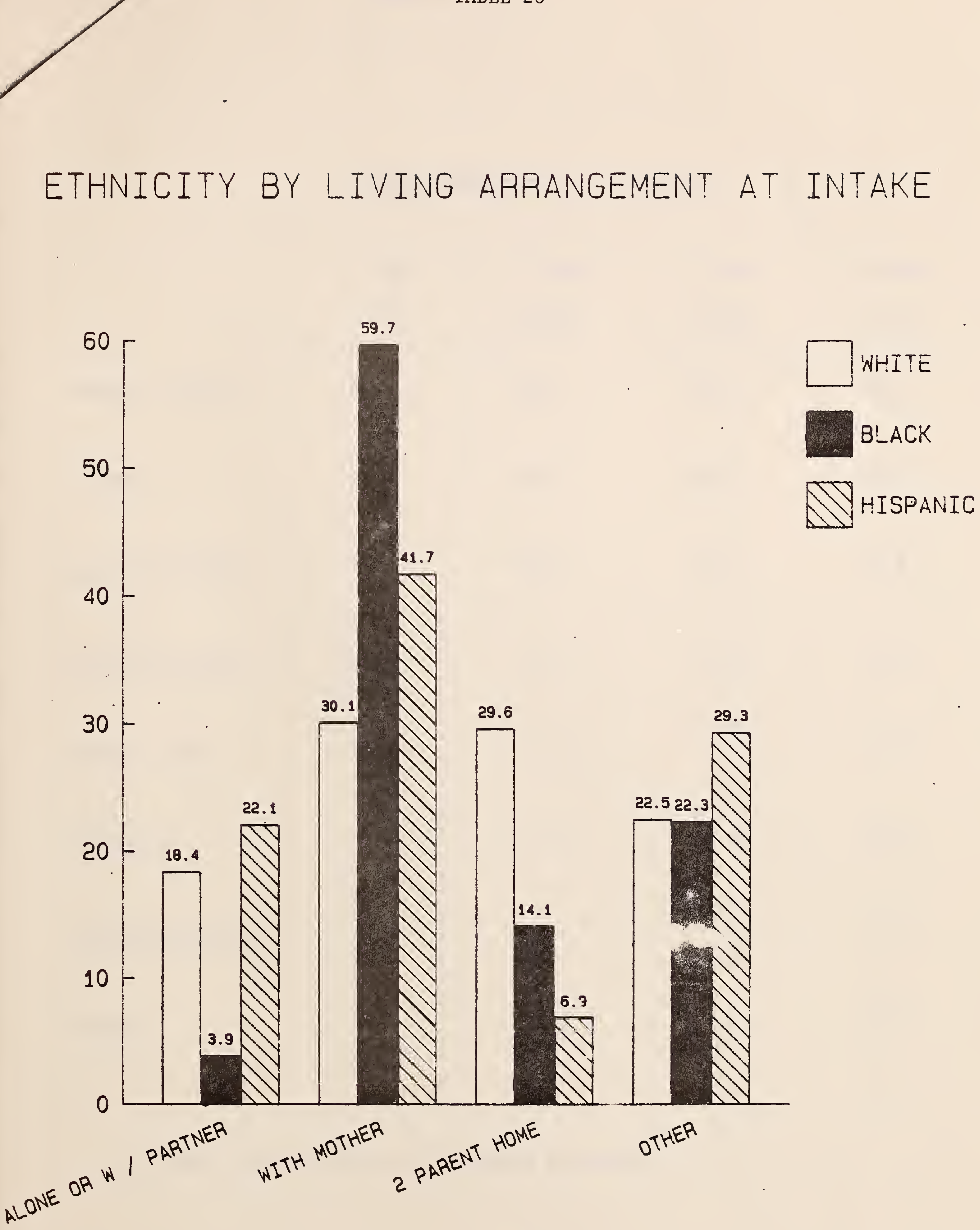

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TABLE 21

LIVING ARRANGEMENTS OF INFANT (a)

	6 MOS n=931	12 MOS n=573	18 MOS n=309	24 MOS n=122
Mother (client)	88.1	90.1	89.6	88.5
Father	28.4	28.1	32.7	32.8
Maternal Family	47.3	45.6	41.1	34.4
Paternal Family	6.8	5.6	7.8	8.2
Foster Care	1.9	1.7	1.0	1.6
Adoption	1.8	2.4	3.9	0.8
Other Relative	2.4	5.4	[illegible].9	7.4
Other	6.9	6.8	5.1	8.2

(a) These categories are not mutually exclusive.

TABLE 22

Table 5

CHILDREN LESS THAN 5 BELOW 100% AND BELOW 200% OF POVERTY

For the 25 Cities with the largest Child Populations in Massachusetts

City/Town	Children Below 100% Of Poverty Number	Percent	Children Below 200% Of Poverty Estimated No.	Percent
Holyoke	1,301	41.0	1,999	62.9
Boston	10,290	34.2	17,495	58.1
Lawrence	1,725	32.6	2,992	56.5
Springfield	3,254	30.9	5,618	53.3
New Bedford	1,849	27.2	3,664	53.9
Lynn	1,341	26.8	2,427	48.4
Worcester	2,461	25.7	4,513	47.1
Fitchburg	649	25.6	1,207	47.6
Fall River	1,536	24.3	3,437	54.5
Lowell	1,542	22.3	3,063	44.3
Pittsfield	706	22.3	1,351	42.7
Haverhill	669	21.5	1,326	42.6
Cambridge	840	21.4	1,709	43.5
Brockton	1,481	21.2	2,972	42.5
Somerville	756	18.9	1,667	41.8
Taunton	547	17.8	1,176	38.3
Quincy	624	16.3	1,282	33.4
Chicopee	538	16.2	1,219	36.6
Malden	436	15.0	904	34.5
Waltham	369	13.4	770	29.0
Medford	369	13.4	809	29.3
Weymouth	361	12.5	803	27.8
Framingham	371	10.8	774	22.6
Plymouth	301	10.2	898	30.1
Newton	194	5.2	548	14.8
MASSACHUSETTS	52,119	15.5	112,798	33.5

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